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Developing a culture of pride, confidence and trust: enhanced collaboration in an interdisciplinary team

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Abstract

Background: Collaborative work is an inherently complex phenomenon. This article explores elements that enhance collaboration and argues that collaboration – understood as evolving processes whereby social entities actively and reciprocally engage in joint activities aimed at achieving a common goal – has not been given sufficient attention in the relevant Norwegian reforms. The Norwegian government implemented the Coordination Reform in January 2012, the aim of which was to provide a sustainable and high-quality health service (Ministry of Health and Care Services, 2012). This article uses the term 'collaboration reform' as this is the literal meaning of the Norwegian title *Samhandlingsreform*, and because collaboration seems to describe the aim of the reform better than coordination.

Aim: To explore how facilitated processes enhance collaboration in an interdisciplinary team, and discuss how the findings inform issues of collaboration between hospitals and municipal health services.

Methods: The design was a cooperative inquiry, that is, a participatory and shared approach to research that aims to facilitate understanding of a shared experience by virtue of cycles of action and reflection.

Findings/results: Taking part in facilitated processes gave the team members added awareness about their work, made them more able to handle complex situations and gave them confidence in their own competence and that of their and colleagues. The processes also gave team members opportunities for enhanced sharing and a broader agenda, to notice and detect, and to create a story about who we are and what we do.

Conclusions: Trusting and knowing each other is a foundation for collaborative work. The facilitated processes provided structure and direction, addressed power imbalances and kept the focus goal-centred. Cross-boundary collaboration between hospitals and municipal health services could improve with an awareness of collaboration as an evolving process involving reciprocity between social entities and participation in joint activities aiming at achieving a shared goal. Formal guidelines and agreements on a local basis could help promote joint responsibility for patients' best interest.

Implications for practice:

- Provision of integrated and coordinated services for patients can be improved by social entities engaging in joint activities
- There is a need for facilitated networks across boundaries in the health services
- Collaboration may improve with greater focus on the processes of sharing tasks and responsibilities
- Knowledge about cooperating partners is crucial to optimise provision of integrated and coordinated services for patients

Keywords: Collaboration, cross-boundary work, practice development, multistage focus groups, Norwegian collaboration reform, facilitation of processes in team

Introduction
The 'Family Ambulatory' is a recently established interdisciplinary team that works with pregnant women and parents at risk of substance abuse and/or mental illness. This is a low-threshold service that aims to ensure easy access to services, motivates parents to seek help and helps to facilitate their navigation of the health and welfare system (Lee and Zerai, 2010). The team is part of the welfare state's front-line services for the prevention of harm to children caused by parents' poor mental health or substance abuse. The belief is that children are helped when parents are supported (FOUSAM, 2016). This article explores how facilitated processes enhanced the team's ability to provide high-quality services. Its findings reveal tacit knowledge of elements that contribute to enhanced collaborative work, and this may shed light on issues concerning the 'collaboration reform'.

Background
The Norwegian welfare state introduced the Coordination Reform in January 2012, the aim of which was to provide a sustainable and high-quality health service (Ministry of Health and Care Services, 2012). This article uses the term 'collaboration reform' as this is the literal meaning of the Norwegian title *Samhandlingsreform*, and because collaboration seems to describe the aim of the reform better than coordination. Prerequisites for the reform are collaboration across different levels of services, cooperation between health workers of various professions in the services and the involvement of patients, service users and patients' relatives. The reform aims to ensure that patients receive the correct treatment, at the right time and place, through integrated and coordinated health services.

> *'Good quality… will be ensured by strengthening the competence of employees and increasing cooperation between the levels of services'* (Office of the Auditor General of Norway, 2015-16, p 7).

The Family Ambulatory team involved in this study is organised under the child medical section in the specialist health services. They also work closely with other specialised services like adult and children's mental health services, services for substance abuse and inpatient family treatment programmes. At the same time the service is more flexible than other specialist services, and is easier to gain access to for families and for health and social services in the civic sector (no formal referral is required and appointments are tailored to the need of each family). In addition to the clinical services (like child assessments, observations and guidance regarding parent-child-relationship, child assessments etc.), the team offers supervision and advice for civic services and organises workshops and seminars (FOUSAM, 2016).

Collaborative work is an inherently complex phenomenon (Patel et al., 2012). Healthcare organisations operate in multifaceted contexts of conflicting demands and objectives, and handle highly challenging daily tasks (Ramanujam and Rousseau, 2006). Consequently, it is not enough to label a group of healthcare professionals a 'team'; attention needs to be paid also to coordination, role allocation and shared responsibility. It is difficult for people to question the norms and values of their own profession or organisation, and this may thwart communication across boundaries (Edmondson and Harvey, 2017). There may also be boundaries of language use and terminology, as well as competing interests or agendas. Working across boundaries gives team members the opportunity to examine their own perceptions in a new light and to reflect on a project or the way they are working (Edmondson and Harvey, 2017). Ramanujam and Rousseau (2006) suggest explicit goal setting, feedback, service redesign and positive involvement of staff as measures that add to the quality of health services. To achieve a positive impact on patient outcomes, there is a need to develop authentic and effective teamwork to facilitate a culture of safety and quality in terms of the way the team is organised, its composition and how it works together (West and Lyubovnikova, 2013).

Bedwell et al. (2012) suggest that teamwork is an instantiation (or form) of collaboration. These authors say both teamwork and collaboration represent 'evolving processes whereby two or more social entities actively and reciprocally engage in joint activities aimed at achieving at least one shared

goal' (p 130). However, collaboration is a broader concept than teamwork, since it can 'involve groups, units, organisations, or any cross-level combination thereof', as well as individuals (p 135). The authors argue that successful collaboration is difficult, possibly because of a 'lack of understanding as to what conceptually and practically constitutes collaboration' (p 128). The 3C Collaboration Model divides collaboration into the dimensions: communication, coordination and cooperation (Fuks et al., 2008). These authors argue that each C contains all three Cs: for example, coordination will not be possible without communicating about tasks and methods and paying attention to the actual acts of cooperation. And, using coordination as substitute for collaboration may ignore the fact that collaboration involves active and reciprocal participation and a process, rather than just focusing on outcomes.

The Norwegian National Strategy for Quality Improvement in Health and Social Services (Directorate of Health and Social services, 2005) underlines the need for a culture of collaboration in the health services. By focusing on what it takes to work well and establish a solid foundation, there is better chance of solving the tasks in line with the requirements for good-quality health services – that they will be safe, secure, effective, integrated and coordinated, involve users and give them influence, use resources in a good way and be accessible and fairly distributed (Directorate of Health and Social Services, 2005).

In this study two parallel facilitated processes were carried out together with the interdisciplinary team to support the team's establishment, provide data for evaluation of its services and strengthen the ability to work as a team. Multistage focus groups were used as a way of including staff perspectives in an evaluation (FOUSAM, 2016) of the total service. At the same time, practice development (Dewing, 2010; Dewing et al., 2014) was used to enhance a culture of person-centredness.

In practice development external facilitators engage team members in developing their knowledge and skills, aiming thereby to change the culture and organisation of care (Dewing et al., 2014). An underlying aim of practice development is that the individual (patient, service-user, family member, health worker) should be given attention and be valued on his or her own terms. Creativity is explored and encouraged and this allows human flourishing. Principles such as collaboration, inclusion, participation and engagement are part of the learning process and also become a part of the way a team works, both within the group and in encounters with service users. High levels of challenge combined with high levels of support are additional practice development principles (Dewing et al., 2014).

Multistage focus groups make it possible to deal with and explore locally defined priorities and perspectives (Hummelvoll, 2008). Development of practice processes can emerge from the experiences of the clinicians themselves (Borg et al., 2010). The groups enable participants to engage actively in re-evaluation of their own and their team's values and aims, thus contributing to the development of sound practice cultures (Eriksen et al., 2014).

Consequently, we can say that both multistage focus groups and practice development involve personal and professional reflection, value each person's contribution and provide a structured, yet flexible framework for positive development. The processes are led by facilitators (practice development) or moderators (multistage focus groups). Facilitation makes processes easier through being interactive, iterative and adaptable (Harvey and Kitson, 2015). Similarly, group moderators lead interactive dialogues and adapt questions and reflections on participants' experiences (Borg et al., 2010). Both roles imply distinct leadership of group processes, and a focus on enabling team members to contribute to a positive caring culture.

The aim of this article is to explore how both facilitated processes enhanced collaboration in an interdisciplinary team and to discuss how the findings inform issues concerning collaboration between hospitals and municipal health services.

Methodology

The chosen approach in the main study was cooperative inquiry. This is a participatory and shared approach to research, the aim of which is to facilitate efforts to understand a shared experience through cycles of action and reflection (Ness and Strong, 2013). This approach makes it possible to work together to build new knowledge and see other perspectives (Eriksen et al., 2014). It is also a way of ensuring that the issues that are explored are important from the participants' point of view, not only the researcher's. The knowledge will be close to the experienced reality, rather than describe an external reality (Hummelvoll, 2003). Knowledge is understood as integrated in persons, and the persons involved in a research process contribute by expressing their knowledge based on personal experiences, theoretical insights, as well as professional experiences in the clinical field (Eriksen, 2013).

However, the research question for this article was developed by the researchers without involvement by the participants in the cooperative inquiry. The total process (see grey box in Figure 1) is used as a case that contributes to the context of the team: the Norwegian health system and in particular the discourse about the collaboration reform.

Figure 1: Overall all design of this study
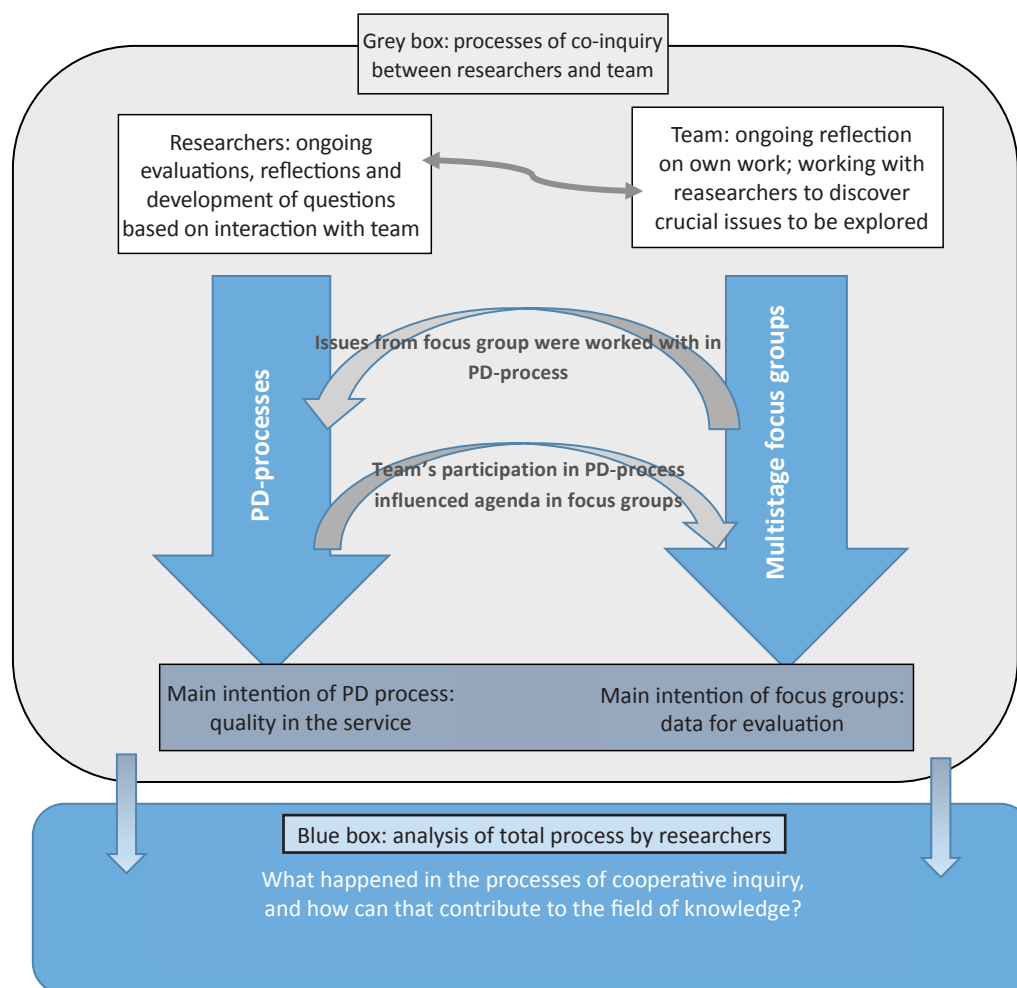
Design

The Family Ambulatory (preventive family team) consists of six people. Four members work with the team four days a week: a nurse with specialist training in substance abuse; a community nurse; a child welfare officer; and a midwife. Two others join the team one day a week: a child psychologist and a

paediatrician. The team was established in October 2014, and the facilitated processes started shortly after this (see Tables 1 and 2). The team members did not know each other in advance. All of them had experience of working with pregnant women and/or families with small children, and had applied for this particular job out of a strong motivation to make a difference in the lives of vulnerable children.

In the practice development processes, the second author (SH) was in charge of (or led) the sessions, although the authors worked together in when planning and reflecting. The staring point was getting to know each other, including exploring values and beliefs in the team. Each activity served a purpose and was well planned but flexible, depending on what happened in the group. The aims evolved in dialogues between team members and the facilitators (the first and second authors). The facilitators made suggestions for further work and involved the team in decisions about useful ways of progressing. The main purpose was to facilitate the development of a supportive culture in the team, rather than to provide data for research. Table 1 shows themes and generated data.

Table 1: Practice development processes

Date	Participants	Agenda	Processes	Data
28.11.14	Second author (SH) and four team members	• Values and beliefs	• Information • Dialogue about theme • Buzz groups • Sticky notes	• Pictures • Field notes • List of values
23.01.15	SH and six team members	• Communication	• 'Angel cards': sharing and linking to last session • Input and reflection: expectations that lead my work • Sharing positive work experience with one partner • Sharing with whole group • Roleplay (facilitators): communication patterns • Reflection: patterns I need to be aware of in my life and in my work	• Roleplay • Field notes
06.03.15	SH and five team members	• Challenge and support	• Icebreaker activity: music and physical exercise • Input and dialogue about support and challenge • Support-challenge diagram • Closing activity: two words about today	• Pictures • Support-challenge poster • Field notes • Programme and goal for each activity
29.05.15	SH and four team members	• Challenge and support • Welcome poster • Writing down 'house rules'	• Input and dialogue about support and challenge • Dialogue about how they see their values and beliefs	• Field notes • 'House rules' • Welcome poster
10.11.15	SH and three team members	• Supporting each other	• Input and dialogue about 'guided reflection' and triade colleague supervision' • Practising triade • Planning how to use triade. • Evaluation (blob football)	• Field notes
23.02.15	SH and four team members	• Supporting each other	• Input and dialogue about 'guided reflection' and 'triad colleague supervision • Practising triad • Planning how to use • Evaluation (blob football)	• Field notes

The focus groups were characterised by a non-directive style of interviewing and topics were introduced to encourage discussion and interchange (Kvale and Brinkmann, 2009). The first author (KAE) was group moderator, with the second author (SH) acting as co-moderator. In multistage focus groups, the same participants meet several times in order to explore questions in depth (Hummelvol, 2008). The time between group work provides the opportunity to reflect further in daily work or to work on some planned action. The main question explored in the group was: how can the team work to develop a service capable of achieving the goals formulated in the plans for the service? Before each new group session, the participants were given a summary based on the last focus group, which enabled them to explore some of the issues raised further. Table 2 shows themes and generated data.

Table 2: Multistage focus group process			
Date	Participants	Questions asked	Data
19.12.14	Both authors and four team members	• What values and beliefs do you apply in your daily work? • How are you working to create a culture of development and learning? • What are your expectations and thoughts in terms of working in the team?	• Plan for group discussion topics • Audio recordings from the group • Transcript of contents • Summary (given to participants before next group)
21.08.15	Both authors and five team members	• How are values and visions challenged in the daily work? • What are your experiences of the work so far? • How do you find a balance between loyalty to the child and loyalty to the parents? • What have your experiences of the practice development processes been?	• Plan for group discussion topics • Audio recordings from the group • Transcript of contents • Summary (given to participants before next group)
20.11.15	First author and five team members	• Are the documents describing the aims for the service consistent with what we are doing? • What needs further attention in our team? • How can we continue to develop the team?	• Plan for group discussion topics • Audio recordings from the group • Transcript of contents

In these processes, the authors were led by occurrences in the field (Bjerg, 2008) and were participants in generation of data. In the roles of facilitators and moderators, the authors tried to keep an open attitude, an open position and to remain sensitive (Dahlberg et al., 2008) to the group and the processes in the group. The analysis represents a shift in focus from being tuned in to the processes with the team members, to being tuned in to the data. Researchers 'facilitate' or 'moderate' by engaging with and being open to the data, and the aim shifts to contribute to the field of knowledge (rather than to a supportive culture). The research questions became clear as part of this engagement and from reading reports about the collaboration reform, which was the context of the establishment of the team.

The team members were informed about the study, and gave written consent before participating in the processes. The information stated that the data would be used for research. New consents were signed (at a later stage) after the team members were given information about this particular article. The study is part of, a project submitted for review to the Norwegian Centre for Data Research (Eriksen, 2015-16).

Analysis
The data were analysed, looking in particular at participants' experiences of how the facilitated processes were helpful in their development of the team. The analysis also moved beyond the meaning of what is said to a deeper interpretation of the text (Eriksen et al., 2014) to reveal elements that contribute to collaboration within the team. Thus, the analysis was guided by questions such as, 'what is happening here?' and 'what are the participants' experiences of the facilitated processes?' (rather than 'what are the participants' experiences in their work?' or 'what were the team's values and beliefs?').

The authors were familiar with the data, since they had been used to present workers' experiences as part of an evaluation of the service (FOUSAM, 2016). Both authors reread and looked at the data again. Elements deemed to be relevant to how the facilitated procesess contributed to collaboration were marked and coded. Words and expressions from the data and key issues were noted and written on a big sheet of paper in random order in the search for themes. A one-page summary was written based on this preliminary analysis. This was reviewed against the total data to ensure that defining elements had not been overlooked. At this stage the authors decided to focus specifically on how the processes enhanced collaboration, not simply on how they were helpful.

The complexity of the data made it difficult to sort into categories, for various reasons: there were different levels of abstraction, some elements concerned process while other were related to outcomes, and some seemed to belong in several categories. As the authors wanted to retain some of the complexity, they developed a model that allowed room for this. This model represented an overall understanding of the findings; it was reviewed against the research question and the final thematic map was developed (see Table 3).

Table 3: Thematic map	
Theme	**Subthemes**
Opportunity for enhanced sharing and a broader agenda	• Getting to know each other and developing trust • Creating space to speak about 'other issues' • Having the opportunity to speak well about each other
Opportunity to notice and detect	• Highlighting problems that need attention and seeing what they are about • Discovering hidden worries members struggle with • Being open to 'provocation'
Opportunity to create a story about who we are and what we do	• Having engaged and interested listeners is a reason to tell the story • Exploring who we would like to be and how we would like to work • Reinforcing and reminding each other of what is important

Findings

From the point at which the team was established, the team leader had made an effort to build a culture of openness and trust that was beneficial to the facilitated processes. The facilitated processes added to this and made it possible to become aware of and further develop the potential of individual team members as well as to strengthen collaborative work within the team. The developments in the practice development process contributed to those in the focus group process and vice versa. Thus both processes involved a variety of approaches, clearer focus and the opportunity to handle complex issues. One example of this was that, because the group had worked on their values and beliefs in a practice development workshop, they seemed ready to speak about their daily work priorities (linked to their motivation, values and beliefs) in the focus group. Similarly, issues that emerged in the focus groups could be addressed in more depth in a practice development workshop. The three themes listed in Table 3 describing how the facilitated processes enhanced collaborative work in the team are described in further detail below. Elements cited from the focus groups are in italics; the names used in the text are not the participants' real names.

Opportunity for enhanced sharing and a wider agenda

The processes enhanced sharing by giving participants the opportunity to get to know more about each other. The team members were new to each other and found it very helpful to participate in facilitated workshops:

'Participating in the PD processes made us more conscious at the start of our work. We had never worked together. It was important to start this early in our work together.'

Sharing was also enhanced, since everybody, regardless of their role in the team, shared their opinions and thoughts. Their variety of professional backgrounds may easily have led to differences in status and significance, but both multistage focus groups and practice development ensured that all voices were heard and valued. This was valued by the team members:

'Questions like "what do we want?", and to get to know each other – it was an enormous help to raise questions like that. And everybody said something and were open about "who I am" and "what is important".'

This sharing also made participants realise that they had previously assumed they knew other team members' understanding, and that expressing opinions that were taken for granted made them more curious and interested in each person's individuality.

Asking questions and providing the space for team members to reflect and express their motivation and values broadened the agenda in the team. They were 'forced' to speak about issues that would not otherwise have been discussed: *'It is very unusual to share our motivation and thoughts. We (usually) don't do that. We (usually) run around.'* At the same time, they appreciated the opportunity to speak about those things: *'I have enjoyed sitting down and listening to my colleagues' experiences – even if this "group-thing" was a bit scary.'*

An added bonus was that 'sitting down' to share and listen gave team members the opportunity to give each other positive feedback. After one team member had shared how she was conscious about creating trust in work-related relationships with mothers (the clients) one of the other team members responded: *'Have you worked like this all the time, Ann? … I find that beautiful! The way you explained it…'* They also valued each other's contribution by mentioning each other's names: *'I believe that we need to – just like Ingrid said – concentrate on this from the start…'* The team leader also received her share of the praise: *'As the Family Ambulatory was a project, I expected teething problems. But everything was ready and organised [by the leader]. That really deserves praise!'* This way of speaking to each other may have added motivation and prompted the fundamental feeling that other team members can be trusted. *'I am not afraid to ask for help. I know the others have a different experience from me, and I can use that. I really appreciate that.'*

Opportunity to notice and detect

As the agenda was expanded, issues that had so far been avoided were discussed. This included participants' professional motivation as well as more personal matters like how working with patients and clients had influenced their personal development, or what they found difficult in the present work situation. The dialogues made it possible to admit to weakness and need for support. They also became aware of several issues that required addressing, such as the need for more knowledge, skills requirements in the team, a better framework for case handling, more structured collegial support, or the pros and cons of written agreements for collaboration with external partners. Thus, the dialogues became a place to discover as well as an opportunity to make plans for practical solutions and development of teamwork.

One team member said: *'To me, it was very helpful to identify problems in the moment'.* And expressing difficulties also made it possible to address them: the team leader reflected after one such dialogue in the focus group: *'I have been uneasy about the way we have organised our work, and it became clearer to me when everyone talked about it.'* And in the next group she reflected further: *'The last focus group was very useful. We knew there was something we needed to do something about, and then we changed things. I'm not sure that we have finished that work, but anyway we are moving forward in terms of how we organise our work and how we discuss cases.'*

The group discussions also brought awareness of the need to be more specific when sharing cases with each other:

> *'We tend to confuse emotions with what is important in terms of the case. Everyone gets eager, and you end up with more questions. And the person presenting the issue ends up having to justify themselves, rather than being helped. It would be helpful if we could be helped to differentiate.'*

Based on this, the team members changed the way they shared tasks and responsibility in their work with clients. They also became aware of the need to differentiate between informing each other about a case, asking for advice and suggestions about the case, or needing to speak because they found the case emotionally challenging.

This culture of sharing and trust in each other may have been a foundation for the confidence they expressed in the team, and in their own ability to do a good job. The dialogues made them aware of each other's competence since they heard the way each person reflected. And when one team member shared the fact that she trusted her own competence because her judgement in an important matter seemed to be in line with that of other team members', the sense of being part of a collaborative and sound professional fellowship was probably strengthened.

Opportunity to a create story about who we are and what we do
By being encouraged to express their experiences and values related to the work, the team members (inadvertently) created narratives about what they do, what they would like to do and how they think and act to fulfil this. These were open-ended and dynamic stories that enhanced confidence, trust and pride. One example of such a narrative was the dialogue following a question about the meaning of their slogan 'Together for a good start'. One participant started out by reflecting: *'Together with the family…'*, and the dialogue continued: *'…to make a good start for the child that is on its way or has been born…'* and *'Together means that we will be open to what is in that family. Stand next to them, not above or below,'* then *'We hope that the mother feels this is a good encounter and that she gets support from being here.'* Together they have said something important about how they want to work, and to 'prove' that this is what they do, the next participant quoted a mother: *'As one mother said: "that someone has time to listen to me". Very often, it is very busy, but here we have time.'* The discussion continued with talk about how the service is different from other services and why the mothers seem to gain trust in the team members. This narrative about their work was created by the group. At the same time the facilitators encouraged and 'provoked' the creation of the narrative, for example by questioning if the teams' loyalty lay with the mother or the child, or by suggesting that it must be difficult for the team members to keep in touch with all the municipalities that refer clients to them. Thus the facilitators represented 'outside' listeners, and a reason to verbalise the stories.

The stories seem to strengthen the experience of being a team and of working together to fulfil a task. They took a step backwards to reflect on how the team has developed: *'We seem to be developing… we succeed in new things. And when the structures are okay we can have more focus on professional knowledge. And work with professional development as a team.'* These shared opinions about the team boost the impression that they are good at their work, and will proceed to become even better over time: *'I think we are moving forward, not least concerning our cases. We have a lot of them now – how can we best share them and to what extent will the other (team members) be involved?'*

Part of the story is pride and happiness: *'It is very nice to do things together. We all like that. Yes. Because we work well together.'* This positive attitude cannot solely be attributed to the facilitated processes. This was a group of highly motivated people who had all chosen to work in this particular field. They may in fact be quite special: *'I'm very happy with my colleagues. I smiled as I walked to work this morning.'* However, the facilitated processes may have increased this sense of pride by encouraging the team members to speak about it and giving them an audience that could acknowledge the good work they were doing.

Discussion

The findings illustrate how the combination of the facilitated processes – practice development and multistage focus groups – provided opportunities that enhanced collaboration in this interdisciplinary team. The multistage focus groups provided awareness and opened up the agenda in the team, and practice development helped strengthen and further develop the team. Each process went in a given direction and was propelled by the other. Both methods helped the team members to get to know each other both as persons and professionals; the methods helped to obtain an overview of structures, motivating factors and practical work, and each included external facilitation that encouraged movement and development in the work. Consequently, the team members gained an added sense of awareness about their work, became more able to handle complex situations and built confidence in their own and their colleagues' competence. The following discussion links the findings to collaboration being defined as: an evolving process; participation in joint activities and achieving a shared goal; and reciprocity between social entities (Bedwell et al., 2012, p 130). This definition is applicable to teamwork as well as to cross-boundary collaboration (Bedwell at al., 2012). The last part of the discussion suggests how knowledge about the processes gained from this specific team may enhance cross-boundary collaboration between hospitals and municipal health services, to reach the goals set out in the collaboration reform – for example, those for care of frail older persons.

Evolving process

> *'Collaboration is a process that can evolve – improving and changing – over the course of its life cycle…' (Bedwell et al., p 130).*

A good foundation can be laid by structures, clear roles, guidelines and agreement about how tasks and responsibility will be shared. At the same time, working together in the best way and in the best interests of the client or patient is never static. The collaboration is 'created' by the involved persons in each present moment. The facilitated processes and the act of 'sitting down' in this study seemed to help the team members to focus on this evolving process. They were able to focus on each other not only as people in the system, task doers and formal responsibility takers, but as human beings with interests, values and social skills. They could focus on their work, not only asking what they should do but also how and why, and even looking for meaning and motivation in their work. They could focus not only on how many cases they were involved in and how to collaborate with other services but also on their identity as a team and how to fulfil their responsibilities on behalf of society.

Participation in joint activities and achieving a shared goal

'Collaboration is joint decision-making processes in which all parties have input' (Bedwell et al., p 134).

> *'The existence of a shared goal is likely the key element separating collaboration from all other forms of shared work… collaborating parties can have both shared and conflicting goals and must, therefore, work through their conflicts to ultimately achieve their shared goal'* (Bedwell et al., 2012, p 134).

Both practice development and multistage focus groups encourage involvement from all participants, and the facilitators (the study authors) were conscious about levelling out power imbalances. This probably supported the team in listening to each other and in encouraging all members to be active in decision-making processes and contribute to definitions of goals for the work. A document, the aim of which was to establish the team and guidelines for its work, had been created before the establishment of the team (FOUSAM, 2016). The facilitated discussions relating to what the goals meant, and how the team could work in line with the guidance, was a way of 'growing into' the tasks and responsibility as team. As professionals, each team member had different tasks and responsibilities in the team – medical, psychological, social, interaction and so on, according to their competence. At the same time, the facilitated processes made it easier for each person to see their personal role as part of the team's total work. The role became clearer with growing awareness of the competence of fellow members. Each person became more confident in their own work since they could be sure that others would

support or take over if needed, and the work became more meaningful because they could see their personal work as part of the work toward reaching the ultimate and shared goal of supporting the parents and preventing harm to children.

The aim of the facilitation was to provide structures and plans to enable the team to develop. The focus on the team's tasks, responsibilities and aims was a good way for the facilitators to 'tune in' to the team and made it easier to tailor the facilitation according to the needs in the team in each session.

Reciprocity between social entities

> *'Collaboration is reciprocal… It requires active, mutual engagement… from all involved parties…, one party dictating or controlling another party cannot be considered collaboration as this type of interaction would better be defined as delegation of work, or even as coercion… engagement or participation from each party does not have to be equal…'* (Bedwell et al., 2012, p 134).

The facilitated processes were examples of active, mutual engagement between the team and the external facilitators. The team needed to welcome the facilitators, allow them to make an impact, be willing to accept the ideas brought in and share their thoughts about the work. This would probably have been impossible if the facilitators had not 'proved' to the team that they were trustworthy and that taking part in the processes was worthwhile. In this case, the team leader invited the external facilitators and created space for the processes by making time available, by speaking positively about the facilitators, and by believing in the methods. For their part, the facilitators allowed room for the leader and acknowledged the competence of the team by being there on the terms set out by the team, by respecting and acknowledging the work they were doing, and at the same time using their position to challenge and push them out of their comfort zone.

There was active and mutual engagement from facilitators and team members, even if the parties had different roles, perspectives and competences. Metaphorically speaking, the facilitation included holding a mirror, providing a magnifying glass, drawing a map and helping the team to build a trophy-cabinet (see Figure 2). Being there and listening made the team and individuals aware of what they looked like and was an encouragement to present the work they were doing in front of the mirror. Asking questions, and pointing a magnifying glass in specific directions made it possible for the team to explore in detail the routines, values and structures of their work. Remind them about the written guidelines, and bringing in theory and models they could use in clinical work was like providing a map that described the terrain. And joining the team in praising small and big achievements, like solving a difficult issue or improving team efficiency, highlighted 'trophies' that were worth celebrating.

Figure 2: Frames and tools in facilitation processes
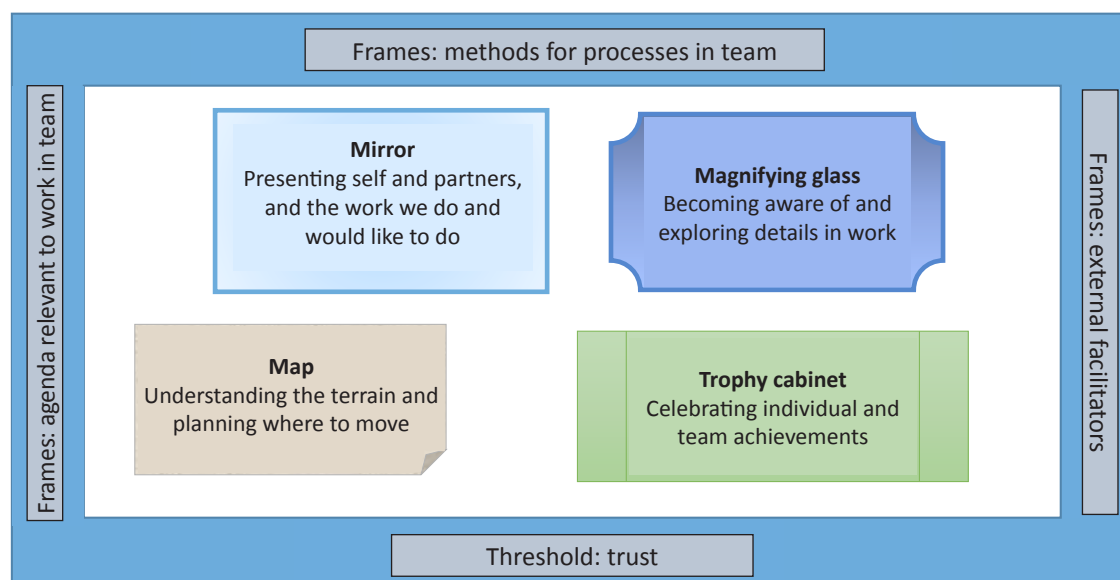
Cross-boundary collaboration

Evaluations of the collaboration reform (Åm, 2015; Haukelien et al., 2015; Martens and Veenstra, 2015; Officer of the Auditor General of Norway, 2015-2016; Rustad et al., 2017) call for better cooperation between hospitals and municipal health services. How can the experiences within this team facilitate this? The first point is that it makes sense to work to enhance collaboration. The reform focuses on cooperation and coordination and this may mean not taking into consideration that providing integrated and coordinated services for patients requires social entities to engage in joint activities. The patient's best interests may or may not be best served even if agreements between services are followed, and there have been many disagreements and disputes in this respect (Martens and Veenstra, 2015). Only social entities can collaborate, and collaboration is 'created' by the involved persons in each present moment. Cooperation agreements can contribute to coordination, but only staff in both levels of health services can collaborate and use their knowledge, skills and experience, for example to ensure proper treatment of frail patients. In one study, nurses (both hospital and community care nurses) experienced that organisational structures directed attention to administrative tasks at the expense of older patients' needs (Rustad et al., 2017). Electronic messaging systems are crucial to facilitate communication between the levels of services, but in cases where the services disagree over whose responsibility a patient is, it is probably better to communicate person to person. Workshops with a focus on specific issues (such as emergency care) are also useful: participants from both service levels explore challenges from patient cases and work together to tailor seamless services. These workshops would benefit from being organised as facilitated processes with frames and tools (Figure 2). This would give the services opportunities to present themselves and their partners and the work each does and would like to do, become aware of and explore details of the collaborative work, understand the 'terrain' and plan where to move, and so be able to praise, celebrate and be proud of big and small achievements.

This study also shows the value of mutual knowledge and trust in order for each person to understand their own role in the collaborative work. Evaluations of the collaboration reform recommend that staff across the levels should cooperate more, work consciously with culture, attitudes and competence (Åm, 2015), develop a culture of cooperation (Officer of the Auditor General of Norway, 2015-2016), and work to gain greater understanding of the other party's perspective (Martens and Veenstra, 2015). Hospitals need to have an understanding of municipal services in order to recommend further treatment and patient rehabilitation. If the services understand what each other can offer, the problem of giving patients false expectations (Martens and Veenstra, 2015) can be avoided. Ballat and Campling (2014) suggest that health service providers should focus their efforts on developing and owning their local pathway. Rustad et al. (2017) suggest a collaborative relationship between hospital and municipal nurses that delivers continuity of care across the providers is vital, especially for the care of older people.

Finally, it is important to not take for granted that collaboration will evolve by chance. Some kind of structure or facilitation process should address the following issues:
- The power imbalance between hospitals and municipal health services
- Working with conflicting goals, given that each service has different tasks and responsibilities
- Working to ensure that patient perspectives are included
- Providing an 'audience' that makes it necessary to spell out aims, motivations and plans

Clinical networks across boundaries could help in this regard. Networks across organisational boundaries could review and address how they are working together, and also help maintain an organisational focus on continuous improvement (Ballat and Campling, 2014). There could be representatives from all services, as well as patient representatives, in all project groups, even if the project is 'inside' one of the services. This will enhance cross-boundary knowledge, while generating important input as to how the providers can work together to form a seamless service for patients.

Conclusion

Facilitated processes contribute to a positive circle in human fellowships. The starting point of getting to know each other creates trust, and trusting each other makes it possible to share and contribute. Each person's contribution is acknowledged and this gives confidence to each person, in themselves and in the shared work. The experience of making a positive contribution gives people a pride in the work, which provides an incentive to sustain the work. Patients should benefit from services provided by confident staff who support each other in delivering high-quality services.

Being part of a high-quality service is a source of considerable professional satisfaction. But within the Norwegian welfare state there are also stories of patients receiving low-quality services, a situation that could change if all parties experienced that they were part of and contributed to a shared story – a story about the integrated and coordinated services patients receive, rather than about 'our' service fulfilling only its designated tasks and responsibilities. This requires facilitation of evolving processes, and opportunities to share and contribute.

In healthcare, true collaboration is often done tacitly, outside of any guidelines, and elements such as confidence and trust between professionals play a big part in that. This article brings these often overlooked factors into the discourse about the collaboration reform. The welfare state can organise and initiate systems and reforms with a goal of delivering high-quality services, but this article suggests that the necessary collaboration requires active and mutual engagement between human beings with shared goals. This article started out by writing that healthcare organisations need to pay attention to coordination, role allocation and shared responsibility; its conclusion is that the challenges involved are best tackled by human beings who trust and show interest for each other, and who work collaboratively in the best interests of the patients they serve.

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