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Towards successful interprofessional practice in health and social care: role clarity, shared goals, and effective communication

Master's Programme Social Policy and Public Health – Thesis based on Existing Data
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Abstract

Although interprofessional practice or 'integrated care' is seen as a priority for health care and social care professionals, there are still a great many barriers that hamper the success of interprofessional collaboration.

The present research assessed the extent to which local interprofessional practice around the facilitation of informal care was influenced by three 'relational factors' (clarity about professional roles, shared goals, and effective communication) and by two structural characteristics of the collaboration (formality of the collaboration and the specific professions included). These conditions are empirically related to outcomes of interprofessional collaboration.

Existing data were analysed, collected by two Dutch Knowledge centres with expertise in Long Term Care (Vilans) and Social Care (Movisie) to evaluate their joint Programme 'In for Informal Care' which aims to improve local collaboration around informal care. Data consisted of 20 evaluative interviews and surveys among 180 health care and social care professionals who participated in the programme. The analysis confirms the importance of the three relational factors for collaboration around informal care. Currently, these three conditions are not fully met, and activities of the participants were aimed at meeting these necessary conditions. In addition, no formal collaboration exists between relevant professionals and coordination of activities is often challenging. Coordination is influenced by relational factors as well as the structural characteristics of the collaboration.

The results provide insight into the necessary conditions for successful collaboration and into some important facilitators and barriers. Deliberate action of municipalities and organizations in Health and Social care is needed to explicate and negotiate professional roles and shared aims among professionals, to discuss any threats to professional identity imposed by the new demands, to create the conditions for effective communication, and to facilitate coordination of activities between all relevant professionals.

Key words: interprofessional collaboration · integrated care · role clarity · shared goals · professional identity

Introduction

Worldwide, interprofessional collaboration has become a priority for health care and social care professionals (WHO, 2010). The general aim of such collaborations or 'integrated care' is to improve access to services, ensure quality of services and patient-centred care, to overcome problems of fragmentation, and to increase innovations, while simultaneously increasing cost-effectiveness (Hofhuis et al., 2018; Nylén, 2018, Valentijn et al. 2013). In the Netherlands, a shift in government policies aimed at youth care and care for the elderly has led to new, interdisciplinary collaboration at the local level, between municipalities, health and social care professionals and volunteer organizations.

However, despite political support for integrated care, and despite empirical evidence for increased effectiveness of interdisciplinary collaboration, there are serious barriers that hamper the success of collaboration between health care and social care professionals (Hofhuis et al., 2018; Wackerhausen, 2009). Barriers are also being acknowledged and addressed in more general research on team diversity. While diversity ideally leads to better outcomes and innovation following from a combination of relevant bodies of knowledge and shared decision-making, often this ideal is not reached in everyday practice (Knippenberg et al., 2004). Several authors highlight the need to investigate the conditions that influence the success of interprofessional collaboration (McNeill et al., 2011; Knippenberg, 2004). Interprofessional practice is especially difficult in new forms of collaboration, where health and social care workers and other actors often lack clarity regarding their professional roles. This is the case for interdisciplinary collaboration at the local level, which is new territory for some actors involved, like policy makers of municipalities and general practitioners (De Wit et al., 2018).

This study aims to provide insight in the critical factors that enable or hamper interdisciplinary collaboration between health and social care professionals in the local context. The prospects as well as specific difficulties of collaboration in this setting are analysed from the perspectives of integrated care and 'professional identity', as advocated in several studies (King & Ross, 2004; Nylén, 2018). Professional identity pertains to people's beliefs about what their profession entails and how they relate to other professionals. Professional identity is likely to be threatened when people enter multi-professional working situations – where other professionals might have other values and priorities and boundaries between professions might be disputed – or when new roles are expected that conflict with what professionals personally experience as the core values and aims of the profession (Currie et al., 2010; Ellis and Ybema, 2010). This is found to potentially harm the quality of interdisciplinary collaboration and integrated care (Siebert and Siebert, 2005).

The present study examines the extent to which collaboration between professionals in the health and social domain in The Netherlands is currently facilitated or hampered by critical 'relational factors' with the potential to mitigate professional identity conflict, and by the structural characteristics of the collaboration

Background

Professional identity is used as a perspective to understand collaboration between professionals in health and social care. First, before defining the concept of professional identity and its implications for interdisciplinary collaboration, the concept of profession itself is clarified. Second, two clusters of crucial factors are distinguished that facilitate or hamper local collaboration between professionals and that are empirically linked to positive outcomes. *Relational factors* focus on the relationships between the professionals who deliver integrated care (Valentijn et al., 2013; Schot et al., 2020). *Structural factors* describe relevant structural characteristics of the collaborative practice.

1. Professional identity

Oomkens (2015) distinguishes four characteristics of professions, based on the work of MacDonald (1995) and Freidson (1970, 2001). The first characteristic is that professions have a unique body of knowledge and qualifications that is complex and respected by people outside of the profession. The second characteristic, following from this uniqueness and complexity, is a high level of work autonomy. Professionals strive for a high level of autonomy, that they will try to uphold or even improve. A third characteristic is control over access to the profession, based on formal work standards and quality criteria. Finally, professions provide services that have high social value and are important for the well-being of groups of individuals.

Different professions vary in the extent to which they comply to each of these four characteristics. In the context of integrated care, medical specialists comply highly to all the four characteristics, resulting in considerable power in constructing and influencing current professional practices and policy changes. Nursing staff and social workers are generally seen as relatively less professionalized groups, as their knowledge base and qualifications are less specialized, and they have less autonomy. This results in less influence on current practices and policy changes (Oomkens, 2015). In the context of integrated care, it can be argued that the work of all participating professionals and even non-professionals comply to the characteristic of have high social value, as it contributes to the well-being of groups of individuals.

Professional identity is defined as the knowledge, beliefs, values, and emotions about what one's own profession entails, which professional roles and activities are or are not part of the profession, and how the profession relates to other professions and actors in the field (Beijaard et al., 2004). Professional identity is not a fixed attribute, coming with the membership of a profession, but is recreated and negotiated in an ongoing interaction with people and the environment. It is influenced by developing social expectations of the profession, local, contextual factors, and personal and professional development and reflection (Beijaard et al., 2004; Schein, 1978). This does not mean that professionals will construe their professional identity as they please. Studies show that professionalization makes professional identity deeply felt, because of the unique body of knowledge and intense professional socialization processes (Cain et al, 2019).

For successful interprofessional collaboration to occur, it is argued that professional identity should be neither 'too fixed', neither 'too loose'. It can be argued that 'saliency' of professional identity is positively related to the extent to which the profession complies to the four characteristics of a profession as described above: a unique body of knowledge; work autonomy; control over access to the profession and high social value. A salient professional identity can either hamper or facilitate interprofessional collaboration. Identity might hamper interprofessional

collaboration as it comes with competition over boundaries, status, power, and resources (Cain et al., 2019). Such competition is found to potentially contribute to negative stereotypes of other professions and actors as a defence mechanism (King and Ross, 2004), to lead to conflict and to have a detrimental effect on the sharing of knowledge between the different professionals (Mitchell and Boyle, 2015).

Mechanisms as described above especially come into play when there is pressure for change imposed by new policies and when professionals of differing status and even non-professionals work together (Cain et al., 2019). Studies show that new policies pose serious threats to the professional identity of all the participating professional groups, as tensions occur between professional identity and expected new roles imposed by new policy (Beijaard et al, 2004; Currie et al., 2010; McNeill et al., 2013). Even with an agreed upon professional profile, there might be considerable personal differences in identity within a professional group. What is found relevant to the profession may conflict with what professionals personally desire, and experience as the core of the profession (Beijaard et al., 2004). Such a friction can for instance lead to burn-out. 'Professional identity conflict' is broadly neglected in everyday practice and in the debates of changing roles of health and social professions and can hamper the quality of both the collaboration and the services delivered (Currie et al., 2010).

A salient professional identity can also facilitate professional collaboration, prompting professionals to expect, seek out and accept valuable knowledge and perspectives from other professions. When professional identity is salient, professionals are more likely to perceive their own professional expertise as a source of relevant input to the collaborative aim (Mitchell and Boyle, 2015).

2. Relational factors

From the perspectives of interprofessional identity and integrated care, three crucial relational factors can be distilled that facilitate local interprofessional collaboration: 1) clarity about professional roles, 2) shared goals, and 3) communication. These factors are empirically linked to patient and provider outcomes (Suter et al., 2009: Gitell et al., 2013) and have the potential to mitigate identity conflict (Mitchell and Boyle, 2020).

Outcomes for patients and clients are equal access to services, patient-centred and population-based care, satisfaction, and quality of life. Patient-centred care acknowledges that diseases are simultaneously a medical, psychological, and social problem, and is based on personal preferences, needs, and values of the patient (Valentijn et al., 2013). Population-based care is based on health-related needs and characteristics of a defined population, resulting in an equitable access to services and distribution of health and well-being in a population (Valentijn et al., 2013). An outcome for the professionals involved is work satisfaction, mediated by work effectiveness and 'management of task interdependencies', following from including the relevant professionals, clarity of roles and responsibilities and management of 'professional identity conflict' (Gitell et al, 2013, Mitchell and Boyle, 2020).

Clarity about professional roles

Clarity about professional roles facilitates interprofessional practice. Evidence shows that when the different professions make explicit what *specialized expertise* they have to offer, this enhances the quality of the collaborative practice and the number of innovation-related activities (Currie &

Spyridonidis, 2018; Mitchell and Boyle, 2020). When professional identity is salient, professionals are more likely to perceive their own expertise as relevant to the collaborative aim and are more likely to expect, seek out and accept valuable knowledge and perspectives from other professionals. When no formal team exists and yet different professionals are supposed to collaborate, there is an even more prominent need to create familiarity with the unique knowledge of other professionals (Mitchell and Boyle, 2015).

Similarly, it is important that professionals take time to gain insight in their own *professional roles* in the collaboration and that of others, following from specialized expertise (Holmesland et al. 2010, Mitchell and Boyle, 2020). In new collaboration stemming from new policies, it is recommended that new and changed roles are defined well in advance of implementation and new roles are negotiated in liaison with the practicing professionals (Cain et al., 2019; King and Ross, 2004). In addition, Schot et al. (2020) stress the factor of negotiating overlaps between work roles between professionals. Working together can create overlaps in who does what, and who is responsible for what, giving rise to ambiguity and conflict. Firstly, professionals are observed to negotiate overlap between roles and responsibilities in general. Secondly, professionals negotiate overlaps when treating individual patients together.

Role clarity contributes to collaborative practice as it leads to developing flexible attitudes towards collaborative work, breaking down negative stereotypes of other professions (King, 2004), and to trust in the activities and competences of other professions, resulting in adequate referral of clients to relevant other professionals and shared decision making between professionals and clients (Nooteboom, 2020). In other words, role clarity helps professionals to focus on the patients' needs and enables a shift from 'provider-driven' to patient-centred care (Suter et al., 2009)

Shared goals

Shared goals enable patient-centred care and interprofessional collaboration (Gitell et al., 2013). Professionals in health and social care share the core value of caring for the health and wellbeing of clients and patients. Following from this, collaboration is valued when this serves the best interests of their populations (Wackerhausen, 2009). Nonetheless, conflicting beliefs or values between the different participating groups of professionals might still exist. Such conflicting beliefs and values are an important trigger of professional identity conflict, with the potential to divide professions (Chrobot-Mason et al., 2009). Therefore, it is important that professionals have insight in the professional values and concerns of the different professions involved (Schot et al., 2020) and that a collaborative aim is formulated that does justice to these values and concerns, or professional identity, of the different professionals involved (Gitell et al., 2013).

Communication

Frequent communication among professionals contributes to the quality of patient-centred care and of collaborative practice (Sutel et al., 2009; Hofhuis et al., 2018). Several studies report the importance of knowing other professionals personally (Schot et al., 2020). Frequent interaction helps building and consolidating a network in which the different actors communicate when necessary, considering specific cases at hand. This contributes to shared decision-making between the different professionals and the patient, family, and informal caregivers, one of the aims of integrated care (Valentijn et al., 2013). Moreover, personal contact and frequent communication is a prerequisite to create familiarity with other professionals and their unique knowledge, leading to

increased trust, and to develop shared values, norms and goals, mitigating professional identity conflict (Chrobot-Mason et al., 2009).

3. Structural characteristics

Enabling and hampering factors to interprofessional collaboration are influenced by the structural characteristics of the collaboration (Reeves et al. 2018). Two important structural characteristics are distinguished:

Formality of the collaboration

The formality of interprofessional practice ranges from tight, formal links to looser, more informal links between members. The typology of Reeves et al. (2010) distinguishes between teamwork, collaboration, coordination, and networking. Facilitating factors for effective collaborative practice differ for these four different types of collaboration.

Teamwork – for example within a family practice or emergency department – encompasses a high level of shared team identity, interdependence, integration, clarity about professional roles and shared responsibility between members. Collaboration is a looser form of interprofessional practice, still requiring shared accountability, clarity about roles, and interdependence between individuals. Coordination is a still looser form. A typical example is the work of a case manager, coordinating the services of other professionals involved. A networking relationship is the loosest form of collaboration, in which interdependence, integration, shared responsibility and even clarity of professional roles are not essential. An example of this type of practice are networks of professionals who share knowledge (Xyrichis et al., 2018).

Specific professions included

Collaboration can firstly be characterised by the number of different professions included. In the context of integrated care, the number of different professionals participated is open ended as professionals decide who participates based on the case at hand (Gitell et al., 2013). A second element is the diversity of the specific professions included. Professions can firstly be characterized regarding compliance to the four characteristics of professionalization as described above. Also, professionals can be characterized by their background in health and social care, including different sub-sectors of health and social care: hospital care, primary and neighbourhood care, and cross-sectoral functions (Schot et al., 2020).

Interprofessional collaboration exists when different health professionals work together, or when health *and* social care professionals work together. In the conceptualization of integrated care, any professional, or even non-professional, can participate in the collaboration (Gitell et al., 2013). A last element is openness of the collaboration for newcomers (Cain et al., 2019; Mitchel and Boyle, 2015).

An overview of the concepts as used in the present study is provided as Appendix 1. The relationship between these concepts is depicted in a conceptual model (Figure 1).

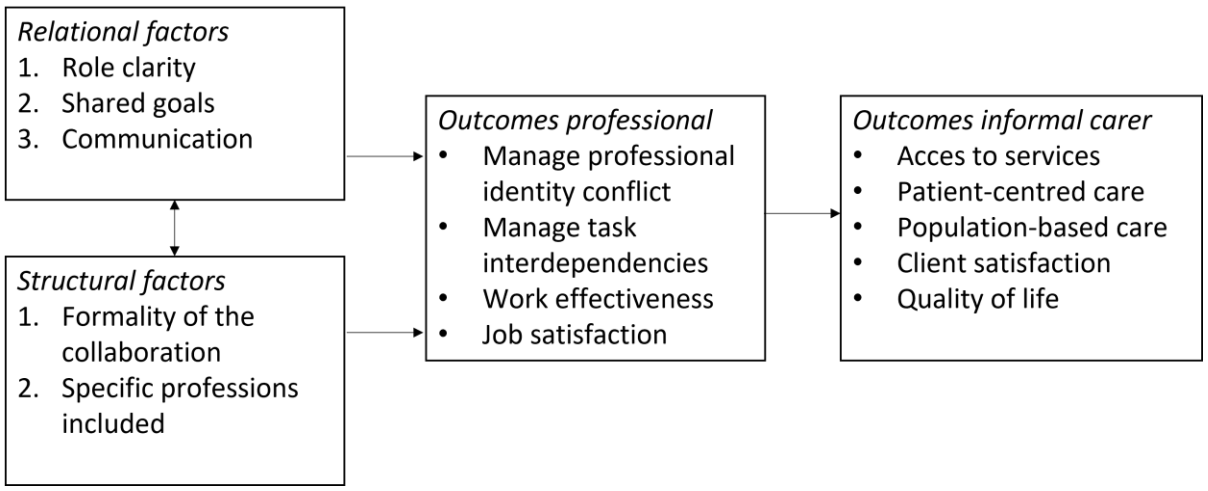

Figure 1. Conceptual model

Research question

The general research question that prompts this study is:
"*To what extent is local collaboration between professionals in the health and social domain facilitated or hampered by the 'relational factors' of: clarity about professional roles, shared goals, communication, and the 'structural factors' of formality of the collaboration, and the specific professionals included?"*

A sub-question is: To what extent are these crucial factors related to the outcomes of the collaboration?

Methods

Context of the study

The present study examines the case of ten local communities of practice at the crossroads of the health and social domain: the 'Local Practices Informal Care'. These practices participated in the Programme 'In for Informal Care' ('In voor mantelzorg-thuis'), executed by Movisie and Vilans between September 2019 and April 2021. The Programme is financed by The Ministry of Public Health, Well Being and Sports, and is aimed at optimizing the facilitation of informal care.

The goal of the local practices is to collaboratively improve the support and structural attention for caregivers, by improving the collaboration between different professionals and between professionals and caregivers. Participants include different health and social work professionals, informal care organizations and municipalities, involved with informal caregivers.

The local practices are selected as a context for this study as they provide a typical example of a new collaboration between professionals in the health and social domain, imposed by new national and local policies.

Data sources

The research is based on a combination of four types of existing qualitative data, collected by Movisie and Vilans to evaluate the Programme.

a) *Written data* on the goals, activities, and outcomes of the Local Practices, according to the 'project leaders': Actions Plans (May 2020, N=33), and Reports on the results of these Action Plans for informal carers and professionals (April 2021, N=33): on average three project plans per Local Practice).
b) *Surveys* after the different 'work sessions' of the local practices. All participants were asked to fill out a questionnaire after five sessions. The questions address the participants' reflections regarding the lessons learned about interprofessional collaboration and their own daily practice (N=324)
c) *Interviews* with the 'theme coordinators' of Movisie and Vilans who advised the Local practices and facilitated the work sessions of the local practices (November 2020, N=10).
d) *Evaluative interviews* with the core group members of the local practices, on the interprofessional collaboration within the local practices, the outcomes, and the hindering and facilitating factors (April 2021, N=10).

See Appendices 3 to 5 for the full overview of questions for the Surveys, Interviews and Evaluative Interviews. Note that these interviews were not designed to address the present research question.

Data analysis

Data from the four sources were analysed using the coding programme MAXQDA. A codebook was developed that distinguishes codes and subcodes, based on the relational and structural factors and the outcomes as conceptualized in the theoretical approach (Appendix 2). The first step in the analysis was to code relevant fragments for the three relational factors: clarity of roles, shared goals and communication, and two structural factors: formality of the collaboration and professions included, distinguishing between enabling and hampering factors. In a second step, for several codes, additional sub codes were added that were distilled from the data and all data were coded for these extra subcodes (Appendix 2). The third step was to link these enabling and hampering factors to outcomes for informal carers and professionals.

Results

1. Background: Characteristics of the local practices

The aim of the local practices is to *collaboratively* improve the support and structural attention for informal caregivers. As part of the programme 'In for Informal Care at home', three interrelated aims were formulated to guide the activities of the practices: facilitating informal care and preventing burn-out of caregivers; collaboration between professionals and caregivers in the care for the patient/loved-one; and coordination and collaboration between professionals.

Following these aims, the local Practices have each chosen three to five topics to address. On each topic, one or more experiments were carried out, during a trajectory of eighteen months. An example of a topic is the early signalling of informal carers by all relevant professionals in healthcare and social care. An example of an experiment for this topic is providing professionals with an e-learning aimed at early signalling and recognizing and preventing breakdown of informal caregivers. A second example of an experiment is conducting a survey among visiting nurses about their current approach to signalling and discussing the results within their teams.

Each local practice consisted of a *core group* of three to four members, including a project leader, and a broader *design group,* in which the core group tried to involve all relevant professionals and organizations. In different subgroups, the design group conducted the practical experiments.

At least five work sessions were organized to facilitate the process, executed by the theme coordinators of the programme, in consultation and cooperation with the core group. These Work Sessions follow the method of Appreciative Inquiry (AI), a change approach that emphasizes strengths rather than weaknesses and problems. Rather than ask participants to list the problems they are facing in the collaboration around informal care, they are asked to explain what is going well, why it is going well, and what they would like to see more of regarding the facilitation of informal care and the collaboration of different professionals and organizations. Work sessions were organized to guide the participants through different steps in AI: Formulating a collaborative aim for the interprofessional collaboration around informal care; Articulating and discovering what is working particularly well for this aim, by sharing both personal positive experiences and general good practices and identifying common elements of these examples; Envisioning a situation where the desired situation occurs more frequently, Making action plans for the desired situation ('experiments'); Performing experiments to realise the desired situation and evaluating the results.

The 180 participants of the Local Practices were professionals (N= 138), volunteers (N=38) and informal carers (N=11). In all practices, at least one informal carer was involved. In all practices, informal care consultants participated. In most of the practices, policy officers of the municipality, case managers dementia, visiting nurses, and social workers were included. In four of the practices employees of General Practices were involved: either a General Practitioner, or a Physician Assistant.

For eight Local Practices, participating in the Local Practice was the first formal collaboration between the participants. The other two Local Practices were based on an existing network, organized around an "Agreement Informal Care" following from a Coalition Agreement of the Municipality.

2. Relational factors

The relational factors clarity about professional roles, shared goals, and effective communication are linked to successful interprofessional practice and to the mitigation of professional identity conflict imposed by new collaboration. This section addresses the extent to which the three conditions are met in the current collaborative practice around informal care, and to which professional identity conflict occurs in the new collaboration.

2.1. Clarity about professional roles

At the outset of the Programme, participants often mentioned 'understanding each other's roles' as an explicit goal of the Local Practices. At that time, professionals had either insufficient insight in the role of others or did not know how they themselves could facilitate caregivers as part of their professional role. According to many of the participants, such clarity is a prerequisite for adequate facilitation by individual professionals, adequate referral to the most relevant professional, and for collaborative action. An often-mentioned example of necessary collaborative action is the signalling of caregivers, from early on, by all professionals involved with informal care. After the first Work Session, a gerontology nurse stated:

> We need to clarify what everyone's role is in signalling overburdened caregivers and how we can contact each other [as professionals]. Urgency is required, it has already taken too long.

As a result of participating in the local practices, participants of all practices reported increased clarity of their own roles and that of others. In the surveys, several professionals stated to have gained *better insight in one's own* role through conversations with other professionals or with the caregivers in the group, like this visiting nurse: "Awareness for me as visiting nurse, seeing and hearing what I as a visiting nurse can do for the caregiver". Other participants observed this effect for other professional groups, for whom, in their view, attention for caregivers was not yet part of their daily routine. In the interviews, one of the core group members elaborates on conversations between professionals and caregivers as a powerful way to gain insight in one's role as professional:

> The personal conversations you have, and the real stories you hear, and just hearing what [caregivers] are thinking. And how you can sometimes make a difference with small things, but sometimes you also conclude: 'Oh dear, that is a very big issue, we can't help you with that'. [Policy officer Municipality-A]

Finally, some participants stressed the importance of taking initiative to give others, outside of the local practices, insight in their own role.

A relatively large share of participants reported to have gained *insight in the specific expertise of others* with respect to facilitating informal care. Most participants made a general referral to the merits of this, as in this quote:

> Through networking, you get to know each other better and you get to know 'what is the expertise of the other?' And you know, 'what does the other have to offer and what can we do together'? [Coordinator Informal Care-B].

Other participants specifically mentioned relevant expertise regarding specific target groups: facilitating caregivers of for instance people with psychosocial and psychiatric problems, dementia, or acquired brain impairment. In addition, expertise related to different categories of caregivers themselves was mentioned, like young caregivers, caregivers with a migration background, or those who combine work and care. Insight into the expertise of several professionals was specifically mentioned as valuable: the informal care consultant, physician assistant, visiting nurse, and case managers dementia, who, according to the participants have a key role in the signalling and facilitation of caregivers. Different participants stated to have deliberately sought out professionals with relevant expertise, inside or outside the local practices. Lastly, participants referred to the merits of transmission of specialized knowledge via training, or information websites. Because of their participation in the Local Practice, professionals have gained better insight in each other's expertise, and this facilitates collaboration in their view. Two participants suggested that in the Local Practice, even more elaborative attention should be given to explicating the specialized expertise of the different participants, considering the relevance of this.

Negotiation of new roles between professionals was not mentioned often by the participants. In one interview, a negotiation between a General Practitioner and social care professionals was described, in which the interests of the GP were discussed: How does attention for informal carers contribute to her work? What does the GP do and what do social care professionals do? In two other interviews, negotiation between employees and management was discussed. Visiting nurses and Social Support Act (WMO) consultants negotiated with management to expand their role and to invest time to better support informal care in their daily work. Several participants referred to other professionals who now, as result of the new collaboration, have a broader perspective on their role.

As a theme coordinator stated:

> For different professionals, more is possible now. Language in the sense of 'I'll do this' instead of 'it's not my job' or 'I don't know if I can'. It is a bit looser, less business like. [Theme Coordinator-A]

A goal of some practices was to strengthen the collaboration between professionals and volunteers. In two interviews, negotiation of the roles and possibilities of volunteers and volunteer organizations was discussed. A core group member observed:

> I see more trust in volunteers, because of positive experiences, resulting in a more prominent role, or collaboration. [Informal Care Consultant]

Explicit *negotiation of overlap between the roles of different professionals* was not often addressed by the participants. In the interview with one Local Practice, overlap was addressed from the perspective of the caregiver who sometimes "has to tell the same story to 'fifteen' different professionals". This local practice simplified the application procedures for support of the caregiver, "by making visible which professionals play which role and in such a manner remove unnecessary overlap." [Coordinator Informal Care-A]

2.2. Shared goals

At the start of the local practices, many participants stated to observe a common goal, or collaborative aim between the different participants. Generally, participants share an awareness of the importance of attention for informal care, see this as part of their professional role, and see the need of collaboration with other professionals involved. According to several participants, this sense of common goal motivated them to act, both individually in daily practice, and collaboratively. Some participants expressed a more nuanced view about the existence of a common goal: even when participants may share the goal in general, "not everyone has the same ideas about how to go about this" [Team Leader Social Organization]. The local practices therefore took the time to specify their aims during the process. Although according to some participants, "this took the speed and the energy out of the process", project leaders saw this as a necessary condition to be able to proceed.

According to many participants, a common goal does not yet exist for the "larger circle" of professionals who cross paths with caregivers in their daily work. Firstly, participants state that some professionals, or professional groups seem to recognize the importance of the aim insufficiently. Specifically mentioned were professionals in primary and secondary care: general practitioners, transfer nurses, who coordinate the transition from hospital to home, and psychologists and psychiatrists:

> We had these conversations with psychiatrists, psychologists and other people who literally said that they didn't do that much with the caregiver. So, they just focus on the patient. [Coordinator Health Care Organization-A].

Similarly, different participants believe that, currently, individual professionals share the aim, but the professional group as a whole, or the organizations behind these professionals, do not. Therefore, one of the primary aims of the local practices was to raise awareness of the importance of the aim among relevant professionals and organizations.

Lastly, some theme coordinators remarked that the collaborative aim seemed to be supported most strongly by those professionals for whom facilitation of informal care is their "core business", like the informal care consultant, for example.

As an outcome of the local practices, it was generally reported that participants now have a clearer common goal, based on the different perspectives and specific expertise of the different

participants. A “start is made” in growing awareness of a broader group of professionals. A core group member stated:

> The people who participated are more aware of the importance and are going to propagate it more and to put this into practice themselves. [Coordinator Health Care Organization-A].

In the surveys, several participants stated to have gained *insight in the values and norms of other professionals.* Most participants referred to gaining such insight in general, for instance: “it is important to learn what drives other professionals”. A informal care consultant gained more insight in the needs of care professionals, who value ‘continuity of care’’ for their patients suffering from chronic conditions. She observed that she herself reasoned primarily from the perspective of the informal carer, for instance, when caregivers want to use ‘respite care services’, providing relief for an afternoon or several days or weeks.

> I had the naive idea that the caregiver could go on a holiday [without further arrangements], but healthcare wants to assure that they can speak with someone should there be a problem and that people can go back home again if things don't work out as planned. I was already dreaming along with this woman about going to Spain, while I first had to ask if there was anyone who could back up for her when she was away for four weeks. These were not the questions that we used to ask. [Coordinator Informal Care-B].

Different participants refer to a connection between the collaborative aim, and the different values and concerns of the participants. A theme coordinator observed:

> From the content of their work, they have a shared ambition. A lot of misery is seen behind the front door, and they all recognise that from their own field of work. I think this motivates them to combine their forces. [Theme Coordinator-A]

This quote also illustrates that participants value collaboration to reach their shared aim. Participants pointed out that, during the process of formulating a collaborative goal in the local practice, it became clear that to reach this goal, it is necessary to collaborate, "Because they realized that they are all working so separately from each other." [Theme Coordinator-B]

2.3. Communication

According to many participants “knowing each other personally” is key for adequate communication between professionals and getting personally acquainted with other professionals and organizations was an important result of the Local Practices. Being personally acquainted was defined as “knowing faces in addition to names”, "having met personally”, and “having insight in someone’s individual expertise and competences”. As a core group member stated:

> If you know each other as professionals and volunteers, you are more likely to coordinate, to inform each other or to refer to each other's services. This may sound strange because we do know each other as professional organisations, but you often must rely on personal contacts and the ways in which you encounter each other. [Social Worker-A]

According to many participants, knowing each other personally is a precondition for collaboration: “making use of each other’s possibilities” and adequate referral to each other’s services. Some participants stated that knowing each other contributes to trusting each other, which is necessary for actual collaboration.

Several participants elaborated on who they have gotten to know better, or *who* should be acquainted with each other. Participants have gotten to know the role of the informal care consultant better and have gotten acquainted with an informal care consultant. In their view, this

will contribute to referral to this person. Also specifically mentioned were policy officers of the Municipality, for instance in the following quote: *"*The municipality often feels not that accessible for people. Knowing a face lowers the threshold" [Policy Officer Municipality-A]. Moreover, participants mentioned acquaintance between health care professionals like home care nurses and physician assistants and the social domain, and between professionals and volunteers and volunteer organizations.

Participants invested in knowing the relevant professionals in many ways, for instance by meeting each other frequently, several times a year, or creating a physical meeting place; visiting each other on the job and organizing informal get-togethers. Several participants expressed that engaging in actual collaborative activities (i.e., the experiments conducted) was a particular strong way to get to know each other, in relation to "just have a meeting where you tell each other about your own activities" [Coordinator Informal Care-B].

Most Local Practices were specifically aimed at improving *communication around specific cases*, aimed at shared decision-making. Although some participants stated that prior to the programme, individual professionals already were accustomed to working together around specific cases, for seven Local Practices, action plans were aimed at the improvement of collaboration or communication in specific cases. According to the participants in these practices, in the current situation, professionals experience difficulty in bringing together other professionals involved around a case. A lack of frequent communication hampers the collaboration between professionals, as illustrated by this core group member:

> Personally, when I have a question, I call people, I contact people. This was also the case when I was a visiting nurse. I think I'm quite proactive in that respect: this doesn't bother me. But this works differently for many care workers. They really aren't that proactive, so they don't get the information they need or not in a timely manner, which gives barriers a much greater chance to exist. [Coordinator Health Care Organization]

The action plans of the practices involved adequate referral to professionals with a different background or from other organizations; obtaining an overview of the professionals involved around a case; consultation between professionals when multiple professionals are involved; making work agreements and deciding on who takes the lead in a specific case.

According to the participants "knowing each other" contributes to adequate communication in specific cases at hand: when you know each other, you are much more likely to consult each other, particularly after positive experiences with each other. As a social worker stated: "When people did a good job for one of my clients, with the next client, I'll call *them".* Another often-mentioned condition is using or creating a formal structure like a Multidisciplinary Consultation, for complex cases in which multiple professionals are involved. Lastly, knowing how particular professionals want to be informed and just what type of information they need was often mentioned as a goal and outcome or the collaboration. Collaboration in the local practice led to specific arrangements about the sharing of information, for instance using digital platforms designed to share information between the patient/client, caregiver, and the professionals involved.

2.4. Professional identity conflict

Interprofessional collaboration may pose threats to the professional identity of all participating professional groups, as they might feel pressure to change their professional approach and priorities. Such threats may hamper the success of interprofessional practice (Mitchel et al., 2011).

None of the participants in the present study expressed that the demand of attention for caregivers conflicts with how they see their role, or their professional identity. Similarly, no referrals were made to other professionals for whom a new demand seems to be in explicit conflict with their professional identity. However, participants do refer to *a lack of awareness* among professionals, or a lack of the need to support the large and growing number of informal carers, like this visiting nurse:

> This [supporting caregivers in collaboration with others] is part of my job! I would like to see other visiting nurses learn to look at cooperation and efficiency differently. You've chosen your profession because of your heart for care, that's what you have to focus on. [Visiting Nurse-B].

In addition, participants referred to professionals who view attention for caregivers as part of their role, like some visiting nurses and transfer nurses, but do not have the permission of their management to act upon these demands, or do not see the possibility to 'indicate' time spent on the caregiver in the current system. Thus, this was related to their perceived level of autonomy. Other visiting nurses, like the one quoted above "just do it". A visiting nurse who did not have the permission to invest time in the cause participated in the Local Practice as a volunteer, before, after lobbying, receiving permission to participate.

As described in the section "shared goals", the professional groups involved differ in the extent to which facilitating informal care is part of their core job. In other words, for some professional groups, facilitating caregivers is more clearly part of their professional identity than for others. For the informal care consultant, the caregiver is the target group, for the visiting nurse or general practitioner, the caregiver is part of the environment of their patient. In addition, for some individual health care professionals, like general practitioners or psychiatrists, attention for the family and caregivers of the patient is clearly part of their professional identity. Some professionals will define attention for caregivers as a new demand, for others it is part of including the larger environment of the patient.

None of the participants refer to some sort of 'identity conflict' imposed by the new collaboration. However, participants do refer to different forms of conflict in the collaboration itself, stemming from different expectations of the specific aims of the collaboration.

According to many participants, the new collaboration led to new insights. Firstly, about the importance of facilitating informal care and about their own role in the matter. In the surveys, the following lessons learned were expressed by participants with various backgrounds: realising that "paying attention to carers is part of the job", realising that "[paying attention to caregivers] was a blind spot" and gaining "insight into how you can fulfil your role". Secondly, participants reported insights about the importance and need of collaboration around the caregiver, e.g.: the need of collaborative action to identify caregivers from an early stage, or to refer to relevant other professionals or services.

Participants refer to the positive effects of engaging in conversation with participants with a different professional background about the facilitation of informal care and discussing each other's wishes and goals. Also mentioned frequently was the equal attention to all professions and parties present: "everyone was heard and there was respect for each other's ideas and opinions" *(Caregiver)*. Many participants expressed appreciation for the work of other professionals in the

collaboration. Also, participants mentioned that the work sessions contributed to insight in *limitations* of specific professionals, imposed by, for instance, laws and regulations. Lastly, participants referred to the merits of combining the expertise of the different professionals involved.

3. Structural factors

Below, factors that enable or hamper interprofessional practice around informal care that follow from the structure of the present collaboration are presented. A distinction is made between professionals included and the formality of the collaboration.

Professionals included

In the interviews, participants reflected on the extent to which "all relevant professions" were included in the local practice. In general, the local practices were satisfied with the variety of professionals they were able to include, and the willingness of different organizations, including the Municipality, to cooperate. On the other hand, participants referred to considerable difficulties in including all professions or organizations which in their view were crucial for a successful approach of the issue, as illustrated in this quote:

> We still have a long way to go, and it is difficult to motivate professionals to participate. For now, we are happy with everyone who wants to join [Coordinator Informal Care-A].

Particularly missed out were active participation of General Practices, which are seen as an important location where caregivers can be found in an early stage. Project leaders discussed different strategies for including the designated professionals: taking the time to discuss the benefits of attention for caregiver for the work of the specific professionals and society as a whole or taking the approach of just starting with the actors already involved, and trying to include these actors later, by showing the outcomes of the collaboration for the caregiver and their loved ones.

The local practices were open to all organizations and professionals who wanted to participate. This was stimulated by the programme and was mentioned by participants as an important lesson learned from the new collaboration:

> Oftentimes we choose to work with the usual suspects because they are so easy to work with. But it is precisely the people who are not so easy to work with that you can get the most interesting things out of. We have learned that now. It will still not be easy, but we have learnt that. [Policy Officer Municipality-B]

Participation of parties of which participants could not imagine beforehand what they could contribute to the cooperation turned out to be valuable. "Because of their visible motivation and enthusiasm for the subject alone" and because of unforeseen contributions and strengths. Professionals and organizations with a large and diverse network, like the library and volunteer organizations, were highly valued for their ability to reach caregivers and professionals and introducing professionals to relevant volunteer organizations. Participating social workers were valued for their ability to include relevant partners who were not yet in the picture of the project leaders. Although openness is seen as a key characteristic of 'integrated care', in the current situation this is not common practice.

Formality of the collaboration

For most participants, collaboration in the 'Local Practices' was the first formal collaboration with other professionals aimed at the facilitation of informal care. The current type of interprofessional

practice can best be described as networking (Reeves et al, 2010). The links between participants of all ten practices are informal. Some practices move to 'coordination', like the practices in which an Informal Care Agreement exists, and some professionals have designated hours to engage in networking and coordinating activities. In none of the Local Practices, a formal alignment of work processes exists. According to the participants of the study a coordination structure would be the desired form of interprofessional practice, as role clarity is a prerequisite for adequate support of individual professionals, adequate referral to the most relevant professional, and for collaborative action.

According to the core group members, participation in the Local Practice helped building a network. The Local Practices provided the conditions to work together with a fixed group of people and organizations who were involved during the whole period. When a member was not able to join anymore, a substitute from within the own organization was arranged. According to one project leader "this shows the commitment of the organizations behind the professionals" (Social Worker-A). This was not the case in the previous situation. Even in the two practices where a network did exist, people did not always know each other personally and were not accustomed to working together in such a systemic way as they did in the Local Practice.

Despite these positive experiences, participants express concerns regarding the stability of the network. Participants firstly stress the difficulty of including all relevant professionals in the network. Secondly, factors were mentioned that hamper the sustainability of the network and the collaboration in itself: No financial means are arranged for the period after the programme ends. To maintain the network, it is important that professionals have time to coordinate the network, to participate in the network and to engage in collaboration in daily practice, as illustrated by this core group member:

> That's the thing with these subsidised things: it has a very temporary character. I found it a bit shocking to hear that [our Local Practice] is perhaps one of the few that will continue to experiment. I would consider that ... a point for attention. When you have a city with a project like this, you should also consider, 'okay this project ends after this period, but what happens after that'? Because yes, informal care will remain. The partners in the field will also remain. It would be a shame for this to peter out and disappear. [Social Worker-B]

All Local Practices have the intention to maintain the network, to execute the collaborative aims with respect to the facilitation of informal care and to ensure that professionals and organizations keep acquainted with each other. As stated by the same core group member:

> I mean, we can agree on paper that we are going to work together. But if you only see each other once a year, then those contacts are not that warm [Social Worker-B].

4. Outcomes

Relational factors are linked to outcomes of interprofessional practice. In this section, outcomes are described for the informal carer and the professional. Intended outcomes of interprofessional collaboration were formulated in the action plans of the local practices and were reflected upon in the evaluative interviews with the core group.

Informal carers

The intended outcomes are predominantly aimed at the informal carer. Most outcomes pertain to increased 'person-centredness', manifested in more attention for caregivers by several professionals

with the patient as their primary target group, and in explicit attention for the specific situation, preferences and needs of the caregiver involved. Increased and equal access to services is a second category of outcomes. Increased access was obtained by dissemination of information about informal care by different professionals and organisations, aimed at different groups of patients and caregivers; adequate referral between different professionals; awareness of professionals of caregivers and checking to make sure that professionals know from an early stage on whether an caregiver is involved; and access to information and professionals/organisations in a physical location in the own neighbourhood.

Several local practices were aimed at equal access of facilitating services for different subgroups of caregivers, like caregivers of people with psychosocial and psychiatric problems, dementia, or acquired brain impairment, young caregivers, or caregivers who combine work and care. Equal attention for these groups can be obtained by including different professionals in the collaboration, with expertise regarding a specific target group. According to several participants, this remains a point of improvement.

Finally, improved satisfaction with services and improved quality of life of informal carers were mentioned as important outcomes. Examples of increased quality of life are being able to make one's own choices, acknowledgement of effort and expertise, being able to spend time by oneself, and decreased loneliness.

Professionals

The reported outcomes for professionals primarily relate to the *management of task interdependencies* between professionals, including knowing which other professionals to involve in a specific situation, being able to contact individual professionals and the actual consultation of these professionals.

Other participants refer to *work effectiveness,* resulting from earlier and better referral to the most suitable professional; using existing knowledge and good practices, for instance to be able to engage in meaningful conversation with caregivers, using 'evidence-based' interview questions, or ways to quickly find out if there is an informal carer involved with the patient.

In addition, outcomes referring to *'management of professional identity conflict'* were reported: participants gained a better understanding of the strengths *and* limitations of other professions, and/or developed a stronger conviction that attention for caregivers fits into their professional role and benefits caregivers as well as their patients and the quality of care.

Finally, increased *work satisfaction* was reported, for instance in the following quote: "It is valuable to discuss their own needs with caregivers. This gives a lot of satisfaction." [Social Worker-C]. Not only the satisfaction of attention for caregivers was reported, but also that of collaboration and coordination with other professionals.

Conclusion

Clarity of professional roles, having a collaborative aim, and effective communication seem to be important conditions for successful interprofessional practice around informal care. In the present situation, these 'relational' conditions are not fully met, and the activities of the local practices were explicitly aimed at meeting these conditions. Participants specifically stress the importance of understanding their own role and that of others in the facilitation of informal care and of making explicit what specialized expertise of the different professionals is relevant for the collaborative aim.

To communicate effectively about specific cases, it is important to know other professionals personally and professionally, including insight in each other's personal expertise and competences.

In the conceptual model presented, explicit attention for the three relational factors among collaborating professionals is a moderator for perceived identity conflict. Participants in the present study did not refer to vital threats to their *own* professional identity imposed by the demand to facilitate informal care. At the same time, participants acknowledged that the facilitation of informal care did not have as much priority as needed, either for themselves or for other professional groups, and is not yet part of the daily practice of all relevant professionals. Participation in the local practices and discussing their own role and that of others in the facilitation of informal carers with other professionals and informal carers, led to prioritizing attention for caregivers in the participants' daily work, as well as insights into how such attention can fit their current professional approach. This indicates that identity threats were mitigated by the activities of the local practices.

A structural characteristic of the collaboration is that, generally, no formal collaboration exists between relevant professionals, and coordination of activities is a challenge. When regular formal meetings between different organizations in the health and social domain do occur, these do not necessarily lead to actual improvements in the collaboration around informal care, including the explication of the roles of the relevant professionals, the negotiation of new roles and overlap between roles, and the sharing of expertise and relevant information with all relevant actors around specific cases.

Discussion

The present research assessed the extent to which local collaboration between professionals in the health and social domain is facilitated or hampered by the relational factors of clarity about professional roles, shared goals, and communication, and the 'structural factors' of formality of the collaboration, and the specific professionals included.

The results show that clarity of professional roles, shared goals, and effective communication are important facilitating factors for successful interprofessional practice. To enhance the collaborative support for informal care, activities of the participants were explicitly aimed at improving these three relational factors, as they are not fully met in the present situation. Related outcomes for informal carers are improved access to services, person-centredness, population-centredness. Outcomes for professionals are management of interdependencies, mitigation of 'professional identity conflict' and work satisfaction. These results support other studies in which these factors were linked to positive 'patient' and 'provider' outcomes (Suter et al., 2009; Gitell et al., 2013).

The structural characteristics of formality of the collaboration and specific professionals included in the collaboration influence the relational factors and the outcomes of the present collaborative practice. In the present situation no formal collaboration exists, while 'coordination' of activities of relevant professionals is desired among participants. Such coordination is needed to get informal carers in the picture of professionals from an early stage on, to systematically involve carers in the care provided by professionals, and to refer carers to relevant services and professionals. In a similar vein, in the present situation, professionals have difficulty involving all relevant professionals.

The importance of leadership is stressed in different studies on interprofessional practice (Currie & Spyridonidis, 2018). In the present study, leadership was not included as a facilitating factor, as in the context of local interprofessional practice, autonomous professionals work together,

and no formal team or team leader exists. However, the results show the importance of coordination of activities. The results of the present study illustrate that successful coordination depends on the relational factors as well as structural characteristics of the collaboration.

The results provide additional insight into the factors that enable or hamper interprofessional collaboration between professionals in health and social care. Greater commitment of professionals with the collaborative aim followed from information on the importance and impact of informal care and understanding the role of their own professional group in the facilitation of carergivers in relation to the roles of others. Role clarity was primarily raised by conversations with informal carers and professionals with a different background. Professionals of different as well as similar backgrounds provided each other with good practices of giving attention to caregivers, incorporated in their daily routine. Professionals discussed why facilitation is important, and how this contributes to both the quality of the care for the patient and to preventing burnout of caregivers. Conversations with informal carers illustrated the impact of care on the personal lives of the carers and provided insight into the ways different professional groups can facilitate the carers they encounter.

It can be argued that the activities of the Local Practices mitigated identity conflict and contributed to meeting the necessary relational conditions for successful interprofessional practice, including coordination of activities. The necessity of negotiation of new roles and overlap of roles was not emphasized by the participants. Such negotiation however is vital for interprofessional practice around specific cases (Currie et al., 2009). This lack of emphasis might be explained by the phase of the new collaboration, in which negotiation would be the next step after acquaintance with the current roles of all relevant professionals involved.

Participants in the present study stated that the active approach in the local practices led to 'better results than regular meetings'. It can be argued that the perceived success of the approach was based on activities that contribute to the three crucial conditions of clarity of roles, explicating a collaborative aim and getting to know other professionals personally, including individual expertise and competences. In addition, the method of conducting experiments and evaluating the results was seen by participants as a powerful means to improve actual practice. This is consistent with literature on implementing Communities of Practice (Carvalho-Filho et al., 2020).

Strengths and limitations of the study

This study provides insight into the factors that enable or hamper interdisciplinary collaboration of professionals in the health and social domain. Other authors highlighted the need to investigate such factors (McNeill et al., 2011; Van Knippenberg, 2004), and more particular, the factors that manage professional identity threats that hamper successful collaboration (King & Ross, 2004; Nylén, 2018). A strength of the present study is that professional identity, a promising but still messy construct is explicitly linked to crucial conditions based on strong concepts from organizational psychology and integrated care: clarity about professional roles, shared goals, and communication and to the structure of the interprofessional practice: formality of the collaboration, and the specific professionals included.

Another strength is the explicit focus on interprofessional collaboration between professionals in health *and* social care, and in looser types of collaboration than 'formal interprofessional' teams. Such collaboration is particularly challenging and less researched than

interprofessional collaboration within one sector, or within existing teams. This study includes a rich variety of professionals and other actors in health and social care, working together in ten different areas in the Netherlands. The results are representative for interprofessional collaboration around informal care, but not necessarily for other topics of collaboration between professionals in health and social care. In addition, the results are representative for the Netherlands, but not necessarily for other countries, in which the health and social sector are organized differently, for instance with relatively more governmental regulation than the Netherlands.

A last limitation regarding representativeness of the data is that all participants participated in the Local Practices. Many of them joined these practices because they see the facilitation of informal care as part of their job and are motivated to improve collaboration between professionals. This might present too rosy a picture of new interprofessional collaboration, and more specifically the mitigation of identity conflict by investing in role clarity, shared aims, and communication.

The present research was based on existing data. A strength of the present study is that the three crucial factors of role clarity, shared goals, and effective communication emerged in interviews with professionals and in surveys and were addressed spontaneously in open questions about their activities and lessons learned from the new collaboration. A disadvantage of using existing data is that it does not allow for targeted and follow-up questioning. Important subjects could not be surveyed systematically, for instance the negotiation of new roles and overlap in roles, and professional identity conflict. This has implications for the depth of the results and validity of the study.

Implications and suggestions for further research

The results have implications for municipalities, professional bodies, and management of organizations in health and social care, suggesting that activities need be facilitated that contribute to the necessary conditions for successful interprofessional practice. For a considerable group of professionals, attention for and cooperation with caregivers is not a main concern, or they do not see how this can be combined with their professional approach, posing threats to their professional identity. Firstly, it is vital to create structures like networks for 'integrated care' and multidisciplinary consultations in which all relevant professions are included. Following the principles of integrated care, this collaboration should be open to all parties who want to join. Subsequently, threats to professional identity should be made explicit and new roles should be explicitly negotiated. As a result, products can be disseminated in which roles of different profession groups are described, with respect to attention for informal care *and* the collaboration with other professionals.

Some authors advocate the need to explicate competences for interprofessional collaboration or integrative care for all professionals in health and social care (e.g., Suter et al., 2009). This study has implications for the (re)formulation of these competences: 'understanding the roles of others in the collaboration' and 'negotiating new roles and overlap in roles' are examples of core competences for individual professionals.

The present study was limited to professionals who had volunteered to participate in the local practices Informal Care. Generally, these professionals were already committed to the case. A suggestion for further research is to involve a broader group of professionals, including the professionals who were underrepresented in this study, like psychiatrists, home care workers and general practitioners. Do they see the support of carers as part of their profession? What helps them

to do this, what hampers them? Data at the level of collaboration around a specific case might especially provide insight in renegotiation of professional roles between professionals, considering the policy of facilitating informal care (Currie et al., 2010). Such research should not only be conducted by academics, but also by the practices themselves, to understand bottlenecks for their specific situation and to overcome these barriers.

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Appendix 1: Overview of concepts and definitions

Concept	Sub-concepts	Description / key elements
Profession		A type of work that complies to four characteristics of a profession: – Unique and complex body of knowledge and qualifications – High level of work autonomy – Control over access to the profession – High social value, contributing to well-being of citizens
Professional identity	Saliency of identity	The strength or saliency of professional identity is positively related to the extent to which the profession complies to the four characteristics of a profession.
	Professional identity conflict	A threat to own professional values imposed by new demands (policy) or collaboration with others, having negative effects on the quality of the of the collaboration and individual work.
Relational factors	Clarity about professional roles	– Professionals have insight into what specialized *expertise* the different professions have to offer to the collaboration – Professionals have insight in their own professional *role* within the collaboration and that of others – New roles are negotiated between professionals – Overlap between roles are negotiated between professionals
	Shared goals	– Professionals have insight in professional values and norms of the different professions – Professionals have a common goal – The common goal does justice to values, norms and concerns (professional identity) of the different actors
	Communication	– Professionals are personally acquainted with each other – Professionals communicate when necessary, considering specific cases at hand, aimed at shared decision-making.
Structural factors	Type or formality of the collaboration	Four types of collaboration and their characteristics: – Teamwork (high level of shared team identity, interdependence, integration, shared responsibility, clarity of roles) – Collaboration (shared accountability, interdependence, clarity of roles) – Coordination (clarity of roles) – Network (none of the requirements)
	Specific professions included	– Number of different professions included: Two different professions, multiple professions, or an open-ended number of professions – Diversity of the different professions included in terms of professionalization level: Full-professions and semi-professions. – Diversity of the different professions included in terms of background – Openness of the collaboration for newcomers
Outcomes interprofessional collaborative practice	Informal carer	– Access to services – Person-centredness – Client satisfaction – Quality of life
	Provider (professional)	– Job satisfaction – Manage professional identity conflict – Manage task interdependencies – Work effectiveness

Appendix 2: Code tree

Relational factors

- Role clarity
  - Insight expertise
    - Insight expertise of other professions (own)
    - Access to relevant knowledge (own)
    - Sharing of expertise between professionals (own)
  - Insight Role
    - Insight in role of others (own)
    - Insight in own role (own)
    - Giving others insight in own role (own)
  - Negotiate new role
    - Negotiate new role with own management (own)
    - Other professionals are open to new role (own)
  - Negotiate overlap
- Shared Goals
  - Insight values and norms
  - Common goal: existence
  - Common goal: fit
- Communication
  - Acquaintance
    - Importance of being acquainted (own)
    - How can professionals get acquainted (own)
    - Who needs to be acquainted? (own)
  - Specific situations

Professional identity

- Saliency
  - Expertise
  - Autonomy
  - Access
  - Social value
- Conflict
  - New demands
  - New collaboration
    - Conflict, difference in interests (own)
    - Engaging in meaningful conversation (own)
    - Appreciation for the work of other professions (own)
    - Merits of combining expertise (own)
    - Engaging in mutual activity (own)

Structure of the collaboration

- Formality
  - Team
  - Collaboration
  - Coordination
  - Network
- Diversity Professions
  - Number
  - Professionalization
  - Background
  - Openness

To be continued on the next page

Outcomes

Informal carer

- Access
  - Dissemination of information (Own)
  - Referral (Own)
  - Physical location (own)
  - Awareness among professionals (own)
- Person-centredness
- Population-based
- Satisfaction
- Quality of Life

Professional

- Job satisfaction
- Manage conflict
- Manage interdependencies
- Effectiveness

Appendix 3: Survey Questions design group (all participants)

Questions Survey, Work sessions 1 to 4

1) What made you enthusiastic during the meeting?
2) In this project, we are working on good cooperation with caregivers. To this end, we worked together during the meeting. What did you do or see that went well in this cooperation? What should we do more often together? What do you want more of?
3) Which insight (or which tip) from the meeting do you want to apply to your own daily activities?

Questions Survey Work session 5 (and follow-up sessions)

1) A 'Knowledge Backpack' including good practices and tools has been made for each experiment. Have you used anything from this 'Knowledge Backpack' lately?
    a. What exactly did you use from the Knowledge Backpack?
    b. What did you think of it?
2) What made you enthusiastic during the meeting?
3) What do you want more of in the cooperation?
4) What do you think was the most important insight/result of your experiment so far and how do you plan to apply this in your daily practice? For example, what are you going to do differently in your own work process or in the cooperation with others?
5) What has the programme contributed since last time?
    a. New contact(s), namely …
    b. Agreements, namely with …
    c. Working visit(s), namely …
    d. New insights, namely …
    e. Co-operation, namely …
    f. Organisation of activity, namely …
    g. Agreements in my organisation, namely…
    h. Otherwise, namely…
6) Is there anything else you would like to share?

4. Appendix 4: Interview Guide Theme Coordinators

The interview protocol for the theme coordinators is based on a model of Kaats & Opheij (2014)[1], distinguishing between five conditions for collaboration.

1) Shared ambition
    a. Do the participants of the Local Practice have a clear picture of the shared ambition?
    b. Is the ambition inspiring for the broader circle of stakeholders?
    c. To what extent is the Local Practice making progress on the shared ambition?
2) Interests
    a. Does the Local Practice explicitly discuss the interests of the participants?
    b. Does the Local Practice make efforts to realise each other's interests?
    c. Does the shared ambition contribute sufficiently to everyone's interests?
3) Relationship
    a. Does the Local Practice include the right people?
    b. Does the Local Practice pay sufficient attention to the quality of group processes?
    c. Does the Local Practice value the way leadership of the Local Practice is organised?
4) Organisation
    a. Does the organisation of the cooperation fit the shared ambition?
    b. Do the stakeholders support the collaboration in the Local Practices?
    c. Can decisions be taken and are agreements kept?
5) Process
    a. Are there clear phases and milestones in the process?
    b. Is it clear who coordinates the process and is this functioning well?
    c. Is the progress and quality of the process evaluated?

[1] Kaats, E., & Opheij, W. (2014). Creating Conditions for Promising Collaboration: Alliances, Networks, Chains, Strategic Partnerships. Berlin Heidelberg: Springer-Verlag

Appendix 5: Interview Guide Core Group Local Practice

Topic	Description / Introduction	Example questions interviewer
Introduction and content of the interview	Researcher welcomes everyone. Introduce framework: anonymity, recording for reporting. Introductory round, possibly based on a question which is already a link to the content.	What are you most proud of when you look back at your practice in the past 1.5 years?
Evaluation of results of the Local Practice	We have already collected a lot of information on your activities, which is why we now mainly focus on the results of these activities and the lessons learned. In addition, we already have detailed information on the results of the experiments, which is why we are asking for the big picture. When necessary, we go back to the core theme and design questions.	Can you tell us what the situation looks like now in [name of Local Practice], around your 'positive core theme'? We are especially curious about concrete changes in the current situation, compared to when you started this programme.
	Follow-up questions concrete changes	– And what does that mean concretely? – So what is different now from when this programme started? – What do you/professionals/caregivers notice about this?"
	Follow-up questions enabling and hampering factors (within own sphere of influence).	– What has contributed to that? What helped? – What was difficult? What got in the way? And how did you solve that? – You are now talking about something you could not change, which was outside your sphere of influence. Were there things you could change, buttons you could turn?
	Provide space for other descriptions of changes around the positive core theme until the descriptions are exhausted, or until everyone has had a turn.	– You have now told .... Can you tell us more about what it is like for you in [name of practice] now around your positive core theme? What else has changed from the start of your practice? – Is there anyone else who has an addition?
	Follow-up questions 3 levels of collaboration, between: 1. Organizations 2. Professionals 3. Professionals and informal carers and clients/patients	– What you just said about your results, that is mainly on the level of... Have you also achieved results on the other levels? – Were there any changes in the cooperation between ... and ...?
Evaluation of the Programme		How did you experience the input of the Theme Coordinator and the programme, including the Work Sessions?
	Follow-up questions	– If you could do it all over again, what would you want to keep the same about the input of Theme Coordinator and the Programme? – And what would you want to see differently?"
Closure		Is there anything else you would like to share that has not been covered today?