2012

Interdisciplinary Management Tool - Workbook

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Relationship statement:

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Contents

Introduction - How to Use this Book.

Welcome to the Interdisciplinary Management Tool (IMT) Workbook.

The workbook has been designed to help members of interdisciplinary health and social care teams to reflect on the performance of their team and explore the latest evidence related to how interdisciplinary teams work best. The aim is that through reflecting on performance and benchmarking against available evidence, that teams are able to both assure the quality of their working practices and, where necessary, take action to develop team working further.

The IMT Workbook was developed through extensive research with intermediate care teams in England, and comprehensive reviews of the published evidence. It combines research evidence around good practice in interdisciplinary team working, with an applied and tested methodology for implementing changes to interdisciplinary working within teams.

There are three parts to the workbook. **Part one** describes a structured, evidence based, organisational development intervention, designed to facilitate improved team working with interdisciplinary health and social care teams. The intervention is designed to take place over a six month period. However, we recognise that all teams are different, and operate in different contexts. The intervention can therefore be adapted to reflect particular teams, contexts and the challenges being faced.

Part two of the workbook contains a number of additional exercises for both teams and individual team members to complete. All you need to do is answer the questions asked, which get you to think about some of the important issues that affect interdisciplinary team working. After each set of exercises there is a summary of relevant research evidence which explains why these particular issues are important for developing better team working. You can use this to reflect upon your answers in the broader context which may stimulate consideration of any change needed in your team or the role you take in your team.

Part Three of the workbook contains advice on how to effectively measure performance of the team, either during the intervention, or longer-term. These tools allow measurement of Workforce Dynamics and Patient Outcomes. Please note however, that some of the patient data gathering methods/tools suggested are aimed specifically at gathering performance data for Intermediate Care and Community Rehabilitation Teams.

The workbook has been endorsed as an appropriate coninuing professional development activity for interdisciplinary health and social care team members, so you could discuss having the IMT workbook recognised as part of your own CPD activities.

It is worth noting that the IMT is not a book of rules. All teams are different: they contain different individuals; have different sizes and structures; work towards different goals; are located in different health and social care organisations; and serve different patient populations. In the same way as each of us can learn from the knowledge and experience of others to be more successful, teams can also learn about how to become more effective from the experience of others.

Who is this guide for?

The IMT was primarily designed and piloted with Interdisciplinary Health and Social Care Teams working in Community Rehabilitation and Intermediate Care with older people. However, the primary focus is on interdisciplinary team working in Health and Social Care and the IMT is designed to be helpful to any interdisciplinary health and social care team. Specifically, the guide is designed for:

- Interdisciplinary teams who want to improve their interdisciplinary team working

- Teams integrating with new teams or new members of teams

- Teams introducing new roles

- Those assisting with and adapting to change

What is Interdisciplinary Team working?

Before understanding interdisciplinary team working we need to understand what team working is. Xyrichis and Ream (2008b: 232) describe team work in health and social care as:

"... a dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making. This in turn generates value-added patient, organizational and staff outcomes"

Enderby (2002: 410) develops this definition by asserting.

"A team requires a definable membership, a group consciousness, a shared vision, a corporate sense of purpose, clear interdependence and interaction and the ability to act in a co-ordinated manner."

Xyrichis and Ream (2008b) found evidence in their study that team work has outcomes for staff, patients, and organisations. Staff outcomes include: job satisfaction; recognition of individual contribution, motivation, and improved mental health. For patients they found that team work leads to: improved quality of care, value-added patient outcomes, and satisfaction with services. Finally, for healthcare organizations; they assert that: team work generates a satisfied and committed workforce, improved cost control, better workforce retention and reduced turnover.

It has to be noted at this point that in this document we use the term interdisciplinary as opposed to interprofessional or multiprofessional. The reason for this is that in all the teams we have worked with there are numerous people in the team who contribute to patient/client care alongside health and social care professionals. Also when we read the literature about interprofessional working, a lot of it seems pre-occupied with professional boundaries and roles. In contrast literature on Interdisciplinary working focuses more on possession of particular forms of knowledge and expertise and how this is shared in patient/client care. Further, the term interprofessional is inappropriate as it does not acknowledge the contribution or perspective of all the other disciplines involved and is often less focused on collaboration and the integration of practice. We therefore use the term interdisciplinary throughout this book as a standard term, that incorporates all professions and disciplines that work within Health and Social Care teams.

Interdisciplinary team working is when two or more health and social care disciplines work together in a team. However the extent to which they collaborate can often be limited to delivery of patient care. Often in practice decision-making includes individual team members making decisions within their own scope of practice within the broader context of all team members sharing decisions related to the overall care package.

The issue of collaboration and integrated working is central to all theories of team working. The central assumption of this body of literature is that the more team members collaborate and work together in an integrated way, the better the outcomes will be.

The theme of integration within interdisciplinary health and social care teams has been the focus of a number of studies. In particular, within the development of the IMT we have referred to and built on the work of Thylefors et al. (2005). Specifically, their theoretical framework on the 3 levels of

integration and the factors that support increased integration has provided a firm foundation for developing the structure of this book.

Part One - The IMT Intervention

Introduction

This section of the Interdisciplinary Management Tool (IMT) Workbook, is an instruction manual for organising and running the IMT's structured organisational development intervention (IMT Intervention) to support interdisciplinary team working. It was developed in response to a recognised need for a structured way to help integrate into practice the best evidence relating to interdisciplinary team working.

If implemented properly, the IMT intervention should help to:
- develop individual knowledge, understanding, and skills in team working;
- strengthen integrated interdisciplinary working within the team;
- build the capacity of individuals and teams to better respond collaboratively to changing team circumstances.

The approach

The IMT intervention was developed based on a number of organisation development approaches, these include Action Research (Waterman et al., 2001), Search Conferences (Williams, 1979), and Action Learning (Revans, 1983).

The IMT's Team Action Learning approach has been developed specifically to help interdisciplinary teams to develop their collective team working and team maintenance skills (as with all relationships, team relationships require effort to develop and maintain).

The approach is iterative. It is recommended that teams participate in a number of events (Team Learning Sets) in which, via a series of structured team exercises, they review and reflect upon current team working and service delivery challenges within their teams. From these discussions a number of issues arise that are areas for possible actions by the team. Each session ends with:

- prioritising issues identified by team members;
- development of an action plan to improve those selected as most important;
- allocation of tasks and timeframes to team members, and;
- agreement of a date for the next meeting.

At the next meeting the process is then repeated. (See figure 1 on page 10.).

This iterative approach allows the IMT Intervention to be flexible so it can be adjusted to meet the requirements of teams and individuals over time. This flexibility also means that the IMT intervention itself will also evolve as different teams continue to adapt to their particular needs and circumstances and find out what works best. As a result, the tool can be adjusted according to the latest evidence, and feedback from teams who use the tool.

Figure 1. Flow Chart of the IMT Intervention
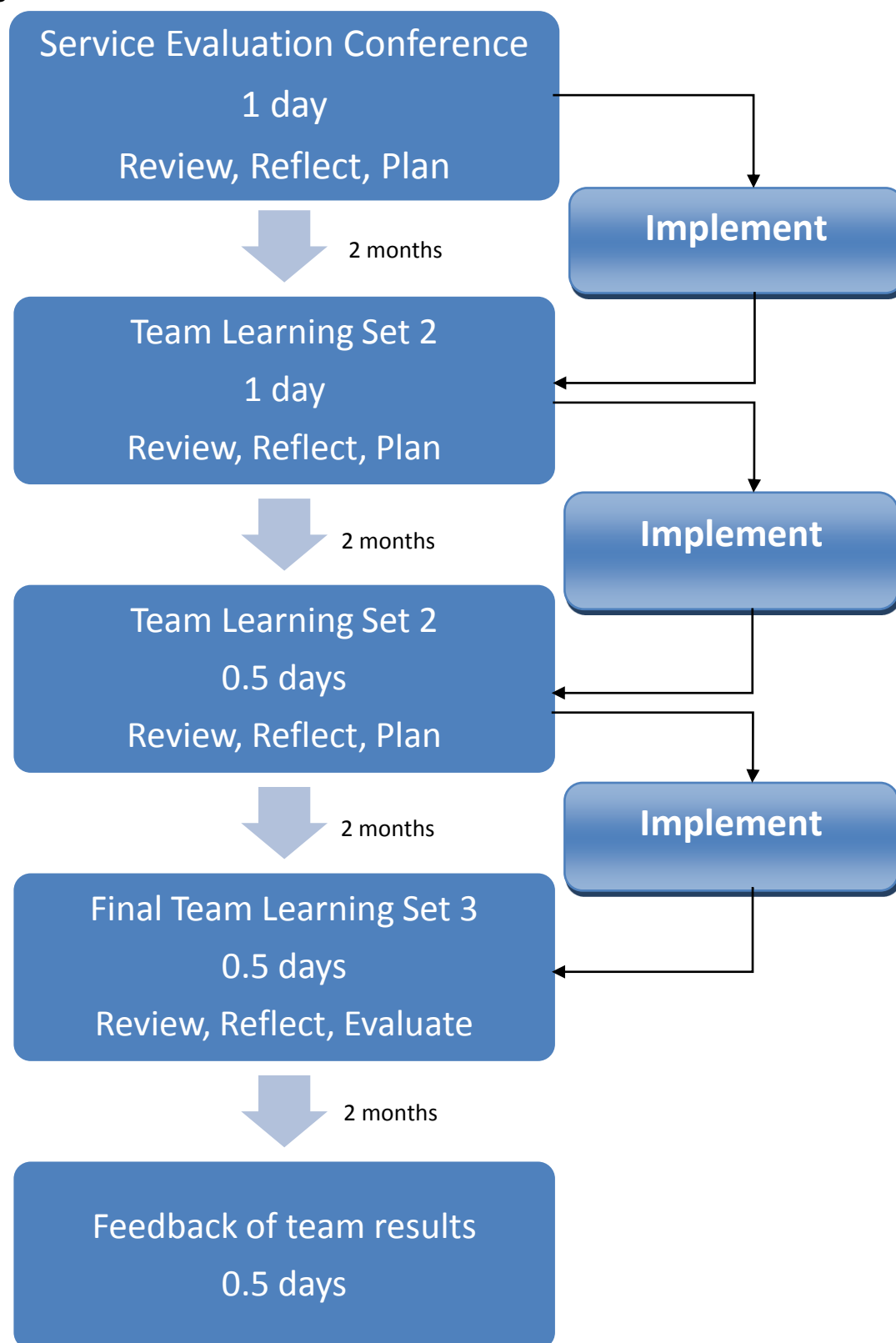
Facilitating the IMT Intervention

In order to maximise the impact of the IMT intervention a facilitator is required to support and facilitate the Team Learning Set process.

This IMT workbook will guide you, the facilitator, to work with teams to address issues around interdisciplinary team working using a structured organisation development approach. The approach is based on the premise that through the use of a facilitator, teams and team members can draw on their own knowledge and experience of their team and wider situation to identify any problems and the best solutions.

All teams are different: they contain different individuals; have different sizes and structures; work towards different goals; are located in different health and social care organisations; and serve different patient populations. Just as we as individuals can learn from the knowledge and experience of others to be more successful, teams can also learn how to become more effective from the experience of others.

What is Facilitation and who can facilitate?

Although facilitation does require skills that can be learned and developed to increasing levels, they are skills that we are all capable of developing and we would encourage anyone with an interest to learn how to facilitate a group.

The word facilitate means to make easy, or help bring about (Webster's Dictionary, 2011), and the job of a facilitator is to make collaborative discussion, and problem solving easier, and maximise effectiveness.

It sounds complicated, but in fact the basic skills of facilitation are about presiding over good meeting practices, such as: -

- timekeeping
- developing and following an agreed agenda
- ensuring everybody can contribute
- clearly agreeing actions
- keeping a good record of the events.

There are however, some higher order skills that an experienced facilitator often uses to improve the impact of the facilitation process. Key is the possession of excellent interpersonal communication skills such as active listening; paraphrasing; balancing conversations to ensure all group members participate in discussions, and that proceedings are not dominated by particular individuals. It is also helpful to develop the ability to work with group dynamics and, in rare cases constructively deal with disagreements and group conflict.

An effective facilitator needs to intervene in group proceedings in a way that promotes creativity and helps to bring about the constructive outcomes desired from the event (Kaner, 2007).

Planning

Participants

The IMT intervention is most likely to have positive impact if all members of the team or service involved in the process are motivated to participate, both as individuals and as a team.

Usually, facilitation takes place with relatively small groups, or teams of 10-20. However, the process can be adapted for larger groups. If you have a larger group, you may need to split into smaller groups during the exercises to encourage equitable participation from all members. This can be more time consuming, so you will need to take this into account in the timings of your activities.

As the primary purpose of the IMT intervention is to develop interdisciplinary team working, ideally only active and integral members of a participating team should take part in the session. If, for example, senior managers who don't work closely with the team sit in on the process, open communication can be compromised and it is more likely that the process will not have the desired impact. If others normally outside of the team do wish to participate, it is desirable that for the purposes of the IMT intervention, they become a co-opted team member. This means that they should participate in all of the sessions and play as active a role as other team members in delivery of the action plans generated. The team, in collaboration with the facilitator should be involved in determining the ideal participants.

The Venue

Identify a venue that is separate to the normal work environment, and free from distractions. If participants from different organisations are involved in the IMT intervention process, try to identify a neutral venue. Ensure that the room is big enough to hold your proposed number of delegates, provides space for small group work, and has places to display flip charts.

Consider the time (e.g. working lunch session) and participants so that the room and seating layout can be planned accordingly. It is important to ensure that the facilitator can be seen and heard by everyone in the room.

Ensure that refreshments are available, and for a long event, like a Service Evaluation Conference, provide a meal or meal break.

Materials

To facilitate IMT Intervention sessions with a team you will need the following items:

- Your facilitator guide – with instructions for the exercises
- Sufficient number of pens (ball point for participants to complete feedback forms, and felt tipped pens for flip charts)
- Flip charts and stands;
- Name badges are useful (a self-adhesive label is sufficient)
- Blu tac to display flip charts

You may also need
- A participant sheet (so you have a record of who attended.
- Hand outs (if you are using them).
- Feedback forms for all participants (so you can find out what they thought of the session and what they learned).
- Post-it notes are useful to capture comments and can be stuck on the wall, or a piece of paper, and sorted into themes.

Facilitation Tips

The role of the facilitator is to make it easy for participants to engage in the discussion and gain value from it. It is very important to set the scene at the beginning of any session, to clearly establish the purpose and create a safe space for participants. Once the session is up and running your job is mainly to:

- stimulate discussion by asking questions;
- gently guide the session and keep proceedings on track
- occasionally link or build on the different points participants make (Search for Common Ground, 2003)

It is important to be familiar with the information in the facilitator guide. Practice saying it out loud in your own words. Better still, if you have time, re-write the script into your own words. You can put in examples and stories if you have suitable ones, but it is advisable to do this sparingly as your role is to facilitate group interaction, exploration and learning – not to give advice, or promote your own ideas. (NB writing it in your own words and practicing it out loud will help you remember it better than just reading it silently to yourself.

Use the guide as a guide, and not a script or a book. You might want to highlight and underline key terms or important concepts to help you remember to cover all the points.

The most important skills of the facilitator is to actively listen to what is being said. Paraphrasing can be a really useful tool to use. It involves restating what someone has said, but using your own words, to check understanding and ensure the most important insights are fully shared. Make sure you don't end up doing all the talking. The facilitators job is not to be "the expert" or to lecture people on what makes a good team.

Six points to remember when facilitating conversation:

1. Facilitate rather than teach.
2. Don't answer questions for the group: it is your job to facilitate their learning.
3. Do reflect back and paraphrase.
4. Remain neutral. It is not your role impose your ideas on the team – use open questions.
5. Encourage the conversation to flow.
6. Help participants think strategically and to see the bigger picture/vision.
7. Do not try to learn the session as a script. Use your own words and examples.
8. Encourage participation from all group members.

Facilitating the workshops

Structure of the IMT Intervention

The IMT intervention consists of four sessions: a one day Service Evaluation Conference (SEC) and three Team Learning Sets (TLS). If data gathering activities are being undertaken throughout the IMT Intervention to measure impact, then a fifth session can be organised to feedback results.

The IMT process can be adapted however, and depending on circumstances more learning set sessions can be organised. (NB less than 3 learning sets is not advised as it is unlikely that the process will have time to have any impact).

One possible outcome of undergoing the process is that teams decide to continue having team learning sets at agreed periods.

Service Evaluation Conference

The Service Evaluation conference (SEC) was developed in accordance with the broad principles of the Search Conference as a participative enquiry and planning method (Emery, 1999) but has distinct differences. According to Emery and Purser (1996) a Search Conference typically last for two to three days. As it was impossible to remove front line health and social care teams from their work for this length of time, we decided in consultation with stakeholders that a day would be an appropriate length, both in terms of what time the teams could spend away from direct service delivery and in order to allow enough time for meaningful, knowledge sharing, exploration of issues and planning. The relatively short space of time available, together with our core aim of delivering an intervention based on research evidence, led us to develop a more structured approach than that of the original search conferences.

As the Service Evaluation Conference is the first session of the IMT Intervention, we strongly recommend that this event lasts a full day; about 6 hours excluding coffee and lunch breaks. Having scheduled coffee and lunch breaks is important for informal networking and team building as well as refreshments.

The SEC consists of a series of exercises that help team members to explore different aspects of interdisciplinary team working that have been found in research to have an impact on team performance. At the end of the SEC the team reviews the issues that have been identified throughout the day and prioritises their importance. They then select issues where they would like to make changes and develop an action plan. The action plan contains concrete actions. Timeframes are established for each action. Particular people or groups are given responsibility for undertaking the actions. At the end of the session the team commits to implementing the plan and meeting again to review progress in two months time.

Team Learning Sets

According to Brockbank and McGill (2004) an action learning set should meet for between half a day and a full day, for a cycle of meetings over an agreed period up to 18 months. As it is difficult for health and social care teams to be away from their primary role for extended periods we devised our Team Learning Sets (TLS) to last for half a day (3-3.5 hours). The Team Learning Sets were more structured than traditional action learning sets as the focus was around developing and learning as a

team, rather than on individual learning within a group setting, which is the traditional focus of action learning.

Team Learning Sets should take place at least every two months during the IMT Intervention period.

We recommend that the first TLS takes place about 2 months after the Service Evaluation Conference. At the TLS the team discusses what has happened since the last session and whether they have seen any changes in the team. In particular, they review their action plan, to assess what progress has been made. Sometimes actions are easily completed. At other time actions have been difficult to progress for various reasons. Where this is the case, the problems in making progress are discussed and new solutions are often found. Sometimes new issues have arisen that the team want to take forward by developing further actions. At the end of each TLS a revised action plan is agreed and a date for the next TLS is agreed.

Service Evaluation Conference – Facilitation Guide

This section provides a template for the one day Service Evaluation Conference that starts the IMT Implementation process.

The template gives a format for the exercises to ensure consistency. However, facilitators may want to adapt some of the exercises according to the needs of the particular team.

Service Evaluation Conference – Sample Agenda

Duration	Timing	Programme	Facilitation phase.
1 hour 40 mins	0930-1000	Introductions (horseshoe)	Contracting
	1000-1010	Why we are here	
	1010-1030	Success criteria	
	1030-1040	Working together	
	1040-1110	Characteristics of an excellent team	Team assessment
20 mins	1110-1130	Coffee	
1 hour	1130-1200	Values exercise	
	1200-1230	Professional development	
40 mins	1230-1310	Lunch	
1 hour 20 mins	1310-1340	Team structure & communication	
	1340-1410	Team size, interdisciplinary configuration & integration	
	1410-1430	Leadership	
1 hour 30 mins	1430-1600	Possible actions	Forward planning
	1500	Working tea break.	
20 mins	1600-1620	Feedback sheets & Closing	Closing

Exercise Name	Introductions (horseshoe) 9.30 – 10.00
Rationale	Introductions start the process of working with a team. The team will probably know each other but will not necessarily have met the facilitator. Team members may know some members better than others. In any case it is useful to have a starting point that is marked and does not rely on assumptions. At this stage in the process anxiety is likely to be raised among the team members so a gradual beginning is useful for allowing members to settle. Finally if the team members have not met the facilitator there will be some assessing of the person in that role as well.
Aims	• For everyone to have spoken about work and a non-work issue. • For everyone to have an opportunity to interact with the facilitator. • For the facilitator to gain some knowledge of the group. • For the group to practice moving to different positions in response to questions.
Process	Seated in a semi-circle ask everyone to stand & **without talking to each other** to: a) put themselves in order of birth date (not age) Jan. to Dec.; b) in order of time since joining the team (this might be more difficult and require discussion once people are in position) (5 mins for this) Then say something like *Could everyone introduce themselves in turn with your name, your role and something that you are passionate about that is not to do with work.* Allow everyone to speak reminding gently if necessary to give the 3 pieces of information. This will give you some insight into how talkative the group is at this stage.
Facilitator Notes	

Exercise Name	Why we are here? (10.00 – 10.10)
Rationale	It is useful to clarify the purpose of the group and to begin to set out the agenda of the meeting by giving an explanation. This will help the team to focus on what they are here for.
Aims	• For the facilitator to give the group the rationale for the meeting • To begin the process of contracting with the group.
Process	Say something like: *We are here to spend some time with you looking at your team and enhancing the effectiveness of the team.* *By concentrating on aspects (domains) of team working and identifying areas where changes might be made. This could lead to developments in aspects of the service for patients.* *We are not setting out to do a service re-design (but some changes in team working may result in changes to the service. (E.g. team meeting times might be an area to consider.)* *We are going to look at various aspects of team working asking questions as we go. We have gathered relevant research to illustrate recent findings about team working that will help us with this project as back ground information.* *The process framework we can use is: - What? So what? What now?* **What?** What is this aspect of team working like? **So what?** What effect does it have on the service? **What now?** Now that we have spent some time reflecting on the team what actions do we want to take as a team? **Ask:** *Is that what you all understood we would be doing as well?*
Facilitator Notes	

Exercise Name	Success Criteria (10.10 – 10.30)
Rationale	This is an opportunity for the teams to start owning their part of the process. Up to now the process has been facilitator led and now the team can start to take a more active part in the process. This also gives you the opportunity to hear what the team thinks is going to happen and what they want. (These are often different from the what the project designers think are the criteria for success.)
Aims	• For the participants to identify what their desired outcomes for the day are. • To give the group the opportunity to have shared ownership of the process • To provide the facilitator with further information about the group.
Process	Write on the flipchart *Today will be a success for me if…* And Say *Working in pairs can you identify what will make today successful for you? You will be asked to feedback for yourself. (Working in pairs is to help to focus your thinking)* (Give 5 mins each) Form the team into 2 groups, take feedback from everyone. Ask for one point from everyone to start with as there may well be overlap. You can always do a second round. (Give 10 mins for this) Bring the 2 groups together to share success criteria. (Give 5 mins for this)
Facilitator Notes	
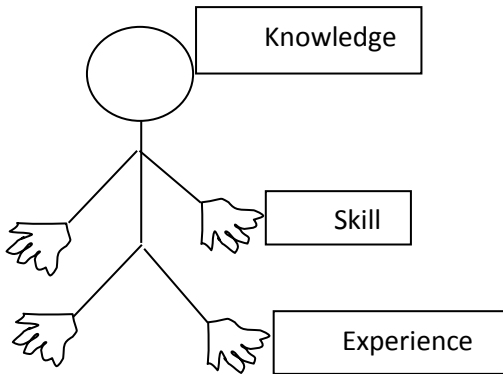
Exercise Name	**Working together 10.30 – 10.40**
Rationale	It is important to have buy-in to the process for people to feel involved and also for the group situation to feel safe for people to work in. The team is going to be asked to work in a way which will be potentially anxiety provoking and team members may be feeling that anxiety. Agreeing some "ways of working together" sets some boundaries for this work for both team and facilitator. Agree confidentiality and any other group behaviours that people need to be able to contribute. (This will be quite concise but it will be a balance between establishing a group agreement and "getting to work")
Aims	• To create a framework within which to build safety and trust.
Process	Ask the group: *Given what we are here for and what you want to get out of the process, what do you need to agree about working together in order to be able to contribute to this group?* There may be some reticence at this stage, so you may help (if no one offers anything) to agree confidentiality as being something like "*let's take away the learning about team work from today rather than, who said what. Those details can be left behind.*" Other issues you might want to consider include: Lets agree break times and stick to them. Phones off or at quietest if you need them on.
Facilitator notes	

Exercise Name	Characteristics of an excellent team (10.40 – 11.10)
Rationale	For the team to explore what they already know about effective team working
Aims	• Purpose of the exercise is to invite team members to think about characteristics of a high performing team and then see how their team can develop towards those characteristics.
Process	**On your own**, *Think of the characteristics of a high performing team. Make notes if you want.* **Get together with one other person** (or 3s if appropriate) add to your lists (5 mins for both exercises) Now in 2 groups, have a group brainstorm (10 mins) The characteristics of a high performing team… Remember the rules of a brainstorm: • Anything goes • No discussion • What is said gets written. Bring the groups together for (10 mins): Questions: What aspects of your team in this list (could be beginnings of, seedlings) What areas are you happy with? What areas could you strengthen? List possible solutions. Make a list but don't go any further.
Facilitator notes	
	Coffee (11.10-11.30)]

Exercise Name	Values exercise (11.30– 12.00)
Rationale	This exercise begins to explore some individual factors effecting team performance. Participants are asked to reflect on aspects of their own team experience and to share and explore with the rest of the team.
Aims	• The purpose of this exercise is to reflect on our own motivations for working and to notice the range of values that are in the team.
Process	Participants are invited to have a series of conversations with colleagues and then to note key words that came from those conversations. A group reflection/discussion then takes place on values.

I would like you to find a partner who you do not usually work with, or are in a different profession to. Have a conversation on a heading I will give you. We will do this several times and then I will give you further instructions for the next part of the exercise.

What do you find enjoyable about your job?

Often people pull a face here and say "this won't take long!" Gently keep people focussed on the task. It is easy to have a moan but if we really, didn't like the job we could do something about it

After 5 mins Change pairs and have another conversation
What do you find Challenging about your job?

After 5 mins Change pairs again for the last conversation
What motivates you to do your job?

After this part of the exercise, form into bigger groups depending on the size of the team 4s work well, or 6s max.

Give each group a flip chart sheet and pen and ask them to record the key words they remember using from their conversations – KEEP TO ONE SHEET PER GROUP

Enjoyable	**Challenging**	**Motivating**
Autonomy	Time	Sense of equality
Like people	Working to targets	Want to help
		Pays the mortgage

When the groups have had up to 10 mins (stop if they have dried up before then), put the flip charts on the wall. |

	Ask whole team *If there is anything anyone wants to clarify on the flipcharts.* *What do you notice about the lists (similarities/differences, themes?)* (5 mins) Conclude: These are some of the values in the team.
Facilitator Notes	

Exercise Name	Professional development (12.00 - 12.30)
Rationale	Teams need members who are motivated both as team members and individuals. Professional development should be part of both the individual's and the team's agenda.
Aims	• The purpose of the exercise is to give participants the opportunity to think about how they would like to develop and think about opportunities that there are within the team to do this.
Process	Participants are invited to draw a figure on paper and by labelling the figure, identify how they would like to develop over the next x years. *We are going to look at professional development. Where do you see yourself going? What opportunities are there in this team for achieving that?* *I am going to give you a piece of paper and a pen. What I'm inviting you to do is to draw a figure on the paper (don't worry it can be as simple as you like). That figure is you and I'd like to take the opportunity to think about how that figure is going to develop. We don't often have the opportunity to sit and do this for ourselves so this is reflection time for you.* *In order to focus it might be useful to think, what Skills (hands), Knowledge (head) and experience (feet) you want to get (not past experience).* (Give 5 mins for this) Shared in pairs (5 mins for this) and team divided into 2 groups. Then the **most important** thing is fed back to the group from each person and noted on a flipchart (10 mins for this). Whole group brought together to identify: What mechanisms are there in the team to help meet these needs? Are there any ideas for action? Make a list of these but do not look for solutions at this stage. (Keep the list on the wall for use later.) (10 mins for this)

Facilitator Notes	
	Lunch (12.30-13.10)]

Exercise Name	Team Structure and Communication (13.10 – 13.40)
Rationale	This exercise asks some questions about team configurations and prompts reflection on current team practices such as working groups, meetings, communication, roles and responsibilities.
Aims	Purpose of the exercise is to reflect on the structure of the current team and whether this affects how the team works together.
Process	A) Team members are asked to gather around a piece of paper representing the centre of the team in relation to how close they feel to the centre (15 mins). *Why are people in certain places?* *Is there crowding/distance?* *Is this ideal?* *Is there good communication between tiers?* *What relationship do service-users have with the team centre?* *Is there anything they would like to change about current configurations?* B) Team members are asked to gather together regarding the client groups they work with (10 mins). *What relationships do these groups have with the rest of team/other groups?* *Is there good communication between groups?* C) Team members are asked to position themselves in relation to the geographical areas they cover/places they work (10 mins). *Do people have a different relationship with the rest of the team depending on where they work?* *How does communication work between different areas?* D) Team members are asked to position themselves in natural work groups (10 mins) *Is this easy to do, why?* *Do people belong to more than one work group?* *How often do work groups meet together?* *How is the communication between work groups?* List possible actions
Facilitator notes	

Exercise Name	Team Size, Interdisciplinary Configuration & Integration (13.40 – 14.10)
Rationale	This exercise gives participants the opportunity to reflect on the size, professional make-up and skill mix of their team.
	Smaller team sizes lead to increased satisfaction for team members and larger ones lead to better outcomes for patients. This exercise asks some questions about team size and prompts reflection on current team practices such as meetings and communication.
	Often teams are called teams but are a group of people working in the same place. This exercise gives participants the opportunity to check whether their team is integrated as well as it could be.
Aims	• The purpose of the exercise is to reflect on the size of the current team and whether this affects how the team works together and to allow the team members to see the professional groups and roles that constitute the team. Also to consider how much the team members know about each other's role.
Process	Ask team members to put themselves into professional groups or groups depending on their roles in the team. Allow people to go to where they want to stand.
	Configuration Questions:
	• *Ask them what defines each group?*
	• *Are any groups larger or smaller than others? Does this mean that more or less of these roles are needed for the work of the team?*
	• *Are there any groups they think are missing or existing groups they think should be larger/smaller?*
	• *Do they often get together in these groups to discuss issues which are specific to the work they do?*
	• *Do people get together with people from their profession/role outside the team?*
	Integration questions:
	For this part create an imaginary line across the room. Stick a sheet on the wall at one end that says AGREE and one at the oppositte end that says DISAGREE. Ask them to place themselves where they think they are on the line for each of the following statements. After each statement, discuss the positioning of the group.
	• *I could tell you what others do on a daily basis*
	• *I have spent time with the other members of the team*
	• *Other people know what I do on a daily basis.*
	• *I could get in touch with any one of the other people here*
	Size Questions:
	• *What is a good size for a team?*
	• *Good points and bad points about the current team size?*
	• *If it is a large team how often do they see other members & how easy is it to communicate?*
	List possible actions

Facilitator Notes	

Exercise Name	Team Leadership (14.10-14.30)
Rationale	We are going to explore leadership and this requires us to look at leaders and followers. Many tasks or activities that you do require people to take a leadership role. We are not here to assess individual leaders but rather to think about leadership in general.
Aims	• Purpose of the exercise is to explore leadership and followers in a team as a general theme.
Process	*In a team we need leaders and followers. Being part of a team means understanding both those roles. As I said we are going to look at these in general terms today?* *I will give you each a task. Get into 4 groups according to the number I give you 1,2,3.etc (apple, orange, pear)etc* One group looks at: In a team what does a team leader need from followers? What makes leadership easier and more difficult? The other group considers: In a team what do team members need from a leader? What are some things that make following easier and harder? Possible actions in this team? Prompt: How do shared leadership and line management affect the way that the team works? Discuss the fact that they all share leadership responsibilities at times and what they need from each other when playing different roles.
Facilitator notes	

Exercise Name	**Possible actions (14.30-16.00)** **[working tea break at 15.00]**
Rationale	Having assessed certain aspects of the team we have a list of possible actions that may be made to the team and therefore have an effect on the service you deliver.
Aims	• To develop an action plan of changes that the team want to achieve.
Process	Present the lists of possible actions. *Are there actions which relate to specific groups?* Perhaps split into 2 groups for the exercise? Grade in order of difficulty 1 = we could do this easily without too much effort 10 = This would be a huge upheaval. Choose (a number) that you could work on over the next 6 months. For each: Test the options for action What is being proposed? What would we be trying achieve? What would be our success criteria? What would help? What would hinder? Take a decision (will we do this?) Action plan. Who will do what and by when? You might want to consider taking an option per small group depending on the team size. The risk here is that you may end up discussing each proposal twice.
Facilitator notes	

Exercise Name	Feedback Sheets & Closing (16.00-16.20/16.30)
Rationale	It is good practice to finish so that the group is clear that the business is concluded and it is time to join the rest of the world again.
Aims	• To complete evaluation sheets, close and leave members feeling a sense of completion.
Process	Arrange chairs in an uninterrupted semi circle. Distribute feedback sheets and emphasise the importance of completing these for the development and evaluation of the intervention. Agree the time of the next meeting and ensure contact details are available as necessary. Finally Ask everyone to go around and say: *"What have you appreciated about working with your colleagues in this way today?*
Facilitator notes	

Structure for Team Learning Set meetings

Facilitator Instructions

Ask the team to set aside half a day for the learning set. You may need less, but the idea is that the team consider deeply the change activities and processes they are engaged with. If the team approach this as simply a functional task of revising action plans, it is unlikely to succeed. Change requires that people change their behaviour, and for that to happen they have to understand the implications of change and what might stop it happening.

Resources:
- Time: ½ day
- Flip charts
- Markers
- Paper
- Pens
- Post-it notes

The facilitation process

We will use the framework of: -

Me
Us – the team
The world

The idea is to allow time for reflection on the three areas above. The time should be divided between the three areas but with a weighting towards the 2nd and 3rd areas. After reflection the team can identify any new actions they want to take if that is appropriate.

The Team will have identified changes they want to make, or an area on which to work. In the sections below this change or project* is the focus of the question.

(NB *Where the word change is used below it is taken to mean whatever the team has decided to work on. They may end up calling it something different or give it a specific name).

Activities

1. **Introductions.**

2. **Specify the change(s).** You can refer to the Action Plan for these. Perhaps write each on up on a board or flipchart to help keep the focus on this. Take each item one at a time.

3. **Me.**
   - How is the change going for me?
   - How does it affect me and the way I work?
   - What are my successes and what was my part in them?
   - What are the challenges this change brings to me and how am I dealing with those challenges?
   - Is this changing me? My practice? My attitudes?

   Work in pairs. Give team members 5 minutes each (10 minutes total) then take a round of feedback on one thing per person. (The value of the exercise is in the individual thinking, but they do not need to feed back all the detail.)

4. **Team** - as a whole **team**.
   - What is the change we wanted to make?
   - What are we doing differently?
   - What is working well?

   Working with someone different from exercise one, spend 5 minutes in pairs before contributing to a larger discussion. Make a list of these on flip chart.

   Working as a whole group (or two groups if this feels more manageable) facilitate a discussion using the following prompts.
   - How are we as a team benefitting from the change?
   - What intended consequences can we see?
   - Are there any unintended/unexpected consequences?

   If nothing is happening, or the team reports reverting back to old behaviours, you could ask;
   "What are you committed to that stops you from changing?" Being careful not to accuse or blame anyone, it might be interesting to explore what the competing commitment is that might be showing itself as "resistance" to change. (Kegan and Lahey, 2009)

5. **World.**
   - What effect do we think we are having – on patients? On the organisation?
   - If it is working well - what specifically is working well and how can we build on it?
   - If it is not working well - what are the stories of what is happening?

6. **What next for me, the team, the project?**
   - From the conversations and discussions that you have just had is there any adjustment you think you could make to what you are doing?
   - Identify one or two areas (beware of changing the whole change initiative especially near the beginning of the process).
   - Create an amended action plan, with specific deadlines and the names of people who will be responsible for each action.

7. **Evaluation.**
   - Complete Evaluation Sheets

8. **Closing exercise.**
   - What have you valued about working with your colleagues in this way today?

Facilitator Instructions

Ask the team to set aside half a day for the learning set. You may need less but the idea is that the team consider deeply the change activities and processes they are/have been engaged with. If the team approach this as simply a functional task of revising action plans, it is unlikely to succeed. Change requires that people change their behaviour, and for that to happen they have to understand the implications of change and what might stop it happening.

Resources:

Time: ½ day
Flip charts
Markers
Paper
Pens
Post-it notes

Preparation:

Before the Learning Set Meeting, you need to prepare a summary of all three action plans created on the previous meetings including actions/changes that have been completed, and those that are still ongoing.

The facilitation process

The aim for the session is that the group come to fully understand the implications of change and what might stop permanent change from happening. However, it is important to dwell on the positives, i.e. what they have achieved and can sustain and build on - rather than getting stuck in negatives.

The questions are therefore phrased to accentuate and build on the good things (that they can do and influence) rather than all the difficulties and reasons for not changing.

Introduction:

Therefore, it is an opportunity to reflect on the process of being involved in the project: what has been achieved and how the team will carry on from here? The emphasis is not just on the specific changes that they have decided to make, but also about changing the way that they approach work, deal with change and develop as a team.

The meeting will be divided into the following 3 main themes
1) General reflection
2) Specific actions
3) Where to go from here

The first exercise involves thinking about what has worked well and what difficulties there have been at three different levels: firstly, what has the experience been like for you as an individual; secondly, what has involvement in the project meant for the team as a whole; and thirdly, what impact has involvement in the project had for the wider world of service-users and other organisations.

General reflection

Me, the team and the world: -

Me

- *What has worked well in the project for me?*
- *What didn't work so well for me?*
- *What have I personally got out of it?*

Spend 5 minutes in pairs before writing <u>one thing</u> under each category on post-it notes and place them on a flip chart sheet under the relevant headings

Us – the team

- *What has worked well for the team in the project?*
- *What didn't work so well for the team?*
- *What are we doing differently as a result of the project?*

Spend 5 minutes in pairs before writing one thing under each category on post-it notes and place them on a flip chart sheet under the relevant headings?

- *Are service-users having a different experience?*
- *Why is this?*
- *Are relationships with external organisations different?*
- *Why is this?*

Spend 5 minutes in pairs before writing one thing under each category on post-it notes and place them on a flip chart sheet under the relevant headings

Once they have all finished split into three groups ('me', 'team' & 'world') or possibly two groups if they are a small team ('me' & 'team'). Get them to arrange the post it notes into sub-themes.

Smaller groups feedback to the whole team. During discussion (to clarify/expand issues and gain consensus) write up notes on flip charts under sub-headings.

Focus on specific actions

Underlying changes in the action plan

Present the summarised action plan (from the SEC and updates from ALS 1 & 2) and give time to re-familiarise themselves with this. These are the actions that they chose to do.

Split into 2 groups (or 4 groups if a large team) give each team a piece of flip chart paper and pen. Say something like:

"The Action Plan lists specific actions that you as a team decided to undertake. What I want you to do is to discuss in your groups the following questions and write on the flip chart:

What has been achieved?

- Identify the things that they have achieved/completed (it is important that they see progress).
- What has helped to achieve these actions?
- What has hindered achievement of these actions?
- What future actions are planned?

Outstanding actions

- Identify the outstanding actions.
- Has any progress been made on the outstanding actions?
- What has hindered achievement of these actions?
- What future actions are planned?
- (ongoing items will come up, but acknowledge and move on at this stage)
- Feedback into group discussion (possibly check themes back against the first exercises & identify relationships).

Where to go from here?

What changes would you like to continue with?

Say something like:

"So these are the things that have changed for you as a team since we have been working together. So the question I want to ask you now is, bearing in mind the nature of change, what changes would you like continue with?"

Do this as a small group discussion (change the groups though). Each group feeds back to whole group.

"What would you have to do to ensure that these changes continue?"
Prompt:
"Look at your lists from the first exercise – what worked well – how can you continue to build on these things." If they get stuck on negatives – *"When you came up against obstacles how did you get round them?"*

"What things could you do to make sure that what you have achieved in this piece of work, and the changes you have been working on, continue?

Whole group discussion. Write down ideas on a flip chart.

NB: If it is hard to make progress with the above exercises, you feel the team is in danger of reverting to doing what it always does, you could ask.

"What are you committed to that stops you from changing? it might be interesting to explore what the competing commitment is that might be showing itself as "resistance" to change."

(At this point you could consider doing the 'Immunity to Change' exercise from Kegan and Lahey (2009))

What Next – How do we sustain change?

After this reflection the team can identify any outsanding actions from the action plan or new actions they want to take if that is appropriate.

Group discussion (create a final action plan to sustain change).

Evaluation.

Complete Evaluation Sheets

Closing exercise.

What have you valued about working with your colleagues in this way over the course of the project?

Final SEC feedback

This is the structure for final results meetings, when the analysis of patient and workforce data collected by the teams throughout the project dynamics is presented.

Facilitator Instructions

Ask the team to set aside half a day for the learning set. You may need less but the idea is that the team carefully consider the change activities and processes they are engaged with. If the team approach this as simply a functional task of revising action plans, it is unlikely to succeed. Change requires that people change their behaviour, and for that to happen they have to understand the implications of change and what might stop it happening.

Resources:

Time: ½ day
Flip charts
Markers
Paper
Pens
Post-it notes

The facilitation process

We will use the framework of: -

Me
Us – the team
The world

The idea would be to allow time for reflection on the three areas above. The time would be divided between the three areas but with a weighting towards the 2nd and 3rd areas. After reflection the team can identify any new actions they want to take if that is appropriate.

The Team will have identified changes they want to make or an area on which to work. In the sections below this change or project* is the focus of the question.

(NB *Where the word change is used below it is taken to mean whatever the team has decided to work on. They may end up calling it something different or give it a specific name).

Activities

Introductions: One thing that they each would like to get from the session. Write up.
Review change(s) achieved. Give copies of the summary Action Plan.

Team – in pairs
- What changes did we make?
- What did we achieve?
- What are we doing differently?

3 minutes then feedback.

Me – in groups of 4 (someone different)
- How did the project go for me?
- What did I get out of it?
- How did I find the project?

3 minutes then feedback.

World – whole group
- What effect do we think we have had/are having
  - on patients?
  - on the organisation?

Presentation

Patients – present the patients section
- Demographics

- Living arrangements
- Source of referral

Discussion –
What do you think about the results?
Is there anything you were unaware of?
Is there anything you need to do in response to the data?

Patient needs and outcomes – present the data
- Levels of care
- TOMS
- EQ5D
- Pat Satisfaction

Discussion –
What do you think about the results?
Is there anything you were unaware of?
Is there anything you need to do in response to the data?

Your Team – present the data
- WDQ
- MLQ

Discussion –
What do you think about the results?
Is there anything you were unaware of?
Is there anything you need to do in response to the data?

Present the summary of the project
How have I found the project overall?
Was gathering the data useful? How can we use the data?
Were the learning sets and meetings a worthwhile investment of time?
Did you find the IMT book useful – did you use it?

What next for me, the team?
From receiving the results and the conversations and discussions that you have just had are there any adjustment s you think you could make to what you are doing?

Evaluation.

Complete Evaluation Sheets?

Closing exercise.

Say one thing that you have particularly valued about working with your colleagues in this way over the project?

Part Two - Further Exercises to facilitate ongoing development of Interdisciplinary Team working Skills

Introduction

In this part of the workbook we present a number of additional exercises for both teams and individual team members to complete. All you need to do is answer the questions asked, which get you to think about some of the important issues that affect interdisciplinary team working. After each set of exercises there is a summary of relevant research evidence, which explains why these particular issues are important for developing better team working.

It is important not to try to wade through the exercises in Part Two in one go. It is much better to pick a short section, have a go at the exercises, read the background evidence, then put the book down and give yourself a little time to think about what you have learned. These exercises can be incorporated in the IMT intervention sessions described in part one of the workbook, or done in your team meeting. The process works best if all the members of your team agree to complete sections of the workbook at the same time and then spend a little time discussing the issues that have arisen together.

Motivation and Satisfaction

All teams are groups of individuals who are employed to do a job of work and achieve goals on behalf of the organisation they work within. As a team they share objectives, which they achieve through collaborating together, and through each individual making unique contributions (Borrill et al., 2000). As individuals, we all have personal needs and goals that we want to achieve through work. Money to pay our bills and provide for our families is one obvious material need. However, we also have other needs. Maslow (1987) described this as the need for self-actualisation, which really means that deep down we all want to achieve our potential. For many of us who work in health and social care, our work is more than a job; it is a vocation and a career. We want to make a positive contribution to society and our community, and we value doing work that we feel helps others. We also want to enjoy working with our teammates and feel that we are liked, respected and that our contribution is valued.

If our job and the team we are working in does not offer us all the above it is likely that we will not be totally satisfied. We may even decide we want to leave our team if we become very dissatisfied.

The exercises below are designed to help you to explore some of these issues.

List five things that:

(a) Make you feel good about your job; and,

(b) Make you feel bad about your job.

How do the things you have listed as good make you feel?

How do the things you have all listed as bad make you feel?

Write down two ways in which you think the team could promote "good" factors and reduce the "bad" factors.

How much do these factors replicate the research findings described on page 47-48?

Discuss your answers with a colleague. How much consistency is there in your answers?

In teams where staff feel they are delivering high quality care, staff get more satisfaction from their work and less of them want to leave (Nancarrow et al., 2009b)

In teams where staff feel their managers are effective, staff get more satisfaction from their work (Nancarrow et al., 2009a)

Team based working in healthcare has been shown to deliver substantial benefits, improving both staff wellbeing and performance (Borrill et al., 2000).

Nurse involvement in team work can increase job satisfaction and reduce feelings of alienation. The extent to which nurses and other members of Health and Social Care teams participate in decision-making currently varies between teams and this can affect levels of satisfaction (Cott, 1998).

In teams where there was more collaborative working, and shared learning activities involving clinical case studies, there were clear benefits for patients, carers and the team itself (Miller et al., 1999).

The above statements are about how motivation and satisfaction can improve team performance. However, according to Xyrichis and Ream (2008a) team work not only leads to increased, job satisfaction, recognition of individual contribution, motivation, and improved mental health for staff. It can also lead to improved quality of care, value-added patient outcomes and improved satisfaction with services.

General issues about Motivation and Job Satisfaction

Research into motivation at work has found that the things that make us satisfied at work are often different from those that make us dissatisfied

For example, if we feel we are not being paid enough we might be very dissatisfied. If we were getting what we thought was a reasonable salary though we would be less dissatisfied, but this alone would not necessarily make us feel more satisfied or motivated.

Research by Hertzberg et al. (1959) found that the things we are motivated by are often to do with the type of work we do, for example; - the amount of responsibility we have, or the recognition and sense of achievement we get.

Furthermore, they are often to do with the organisational situation in which we work, such as: - the organisation's policies and procedures, our level of job security, or our relationship with our supervisor(s). Additionally, the things that dissatisfy us are often related to external things we must do and for which there may be carrots or sticks. The motivators are generally personal, such as feeling a sense of purpose and value in what we do, and that we are developing our potential.

Motivators	Dissatisfies
• Responsibility • Achievement • Recognition • Advancement • The work itself • The possibility of growth	• Company policy and administration • Technical supervision • Interpersonal relations with supervisors • Interpersonal relationships with peers and subordinates • Salary • Job security • Personal life • Work conditions • Status
High ←————————— Low Satisfaction Satisfaction	Low ————————→ High Dissatisfaction Dissatisfaction

Career development opportunities

In the previous section the importance of career development opportunities was touched upon in relation to motivational issues.

In organisations that employ a lot of professionals however, opportunities for continuing professional development are even more important. Professional staff are often more likely to view their career as a vocation and be committed to continuing to learn and develop their skills throughout their careers. If insufficient career development opportunities are available to interdisciplinary health and social care team members, it can have a detrimental effect on levels of motivation and satisfaction, and this can ultimately affect the service delivered to patients/clients.

The following questions are designed to help you to explore some of these issues.

Do you have a regular appraisal or supervision meetings?

Do you have the opportunity to talk about your own career development in your appraisal or supervision meetings?

Do the work tasks or projects you are asked to do give opportunities for you to develop in the way you wish to develop whilst achieving the targets of the team?

Do you get access to the training or educational programmes that you need to develop your professional skills and your career?

How well overall is the appraisal/supervision system suited to your own career development needs?

Read the evidence about career development and team performance on pages 51-52. List one change that you think your team might make to make the appraisal system more effective in facilitating career development opportunities and discuss it with your colleagues.

Staff are less likely to say that they intend to leave teams when they feel they have sufficient training and development opportunities to develop their career (Nancarrow et al., 2009a).

Opportunities for career advancement and personal growth are particularly important for Health and Social Care professionals (Borrill et al., 2005).

A key leadership role is developing people and the major organizational mechanism for achieving it is having a well-developed human resource management structures (Borrill et al., 2005).

Health and Social Care organisations with well-developed Human Resource Management (HRM) systems perform better than organisations with less well-developed HRM systems (Borrill et al 2005).

Staff have more positive perceptions of senior managers and report higher levels of job satisfaction and lower levels of intention to leave in Health and Social Care organisations with well structured appraisal systems and individual personal development plans (Borrill et al., 2005).

There is a strong relationship between the sophistication of Human Resource Management practices and patient mortality. Appraisal had the strongest link with patient mortality (West, 2006). A 20% increase in staff appraisals and the training of 20% more appraisers resulted in a reduction of 1090 deaths per 100,000 admissions. The link between human resource development and patient mortality were stronger when the director of human resources was a voting member of the executive board (Borrill and West, 2004)

A link has also been found between the sophistication of training practices and patient mortality. Organisations with a high-level access to formal training had a 3.5% lower patient mortality rate (Borrill et al 2005).

According to (Caley and Reid, 2003) there are nine key factors that influence the strength of the workplace as a site for learning and development these were grouped in three main areas:

Systems factors: long-term planning for staff development, organisation and management of work to facilitate learning and significant organisational support for employee learning.
Policy factors: consideration of organizational and individual learning needs when undertaking workforce planning, enabling experience to be shared by creating informal learning opportunities, and maximising learning opportunities via providing financial infrastructure and technology support.
Cultural factors: fostering openness and sharing, encouraging communication, and adhering to clearly and publicly stated values that promote learning.

This study also found that learning and development activities often do not have impact because the systemic supports that allow learning to become part of practice are not in place.

Although most of us want to develop our skills and realise our potential in some way, it is easy for all of us to neglect long-term development goals because of the immediate pressures we face.

"To ensure team members invest enough time in development they therefore need a practice leader to focus on issues related to team development, to coach and guide colleagues through learning situations that will ultimately improve team function and practice." (Maister, 1993: 208)

However, there is a tension between individual professional development and the needs of the interdisciplinary team. Focus on individual skill development, individual accountability and achievement, which are continually reinforced by traditional HRM practices within health and social care systems, often encourages individual behaviour which is not consistent with the competencies required for effective team work (Leggat, 2007).

Autonomy

Autonomy literally means "one who gives oneself his/her own law". It is the right to be self-governed and politically independent with immunity from arbitrary exercise of authority.

Autonomy is one of the cornerstones of professionalism. A professional undergoes a specialised training that equips them with high levels of skills and knowledge about a particular field of work, such as medicine, nursing, social work, occupational therapy, or law. Traditionally when someone becomes a professional they are deemed to have such specialised knowledge and skills that they are given authority to act autonomously in the best interest of their patients or clients, even when there may be pressures (from politicians or managers) to do otherwise. The independence of professionals is particularly encouraged in democratic societies as it is seen as a safeguard against the state becoming too controlling or tyrannical.

The challenge in health and social care is that we are developing systems that demand, more than ever before, that health and social care workers work more closely together with each other to coordinate their efforts. This more coherent systems approach aims to maximise outcomes for patients, and is the main driver for the development of interdisciplinary team approaches.

The obvious tension between individual professional autonomy and increased collaboration and coordination required in team approaches can lead to problems.

The following questions are designed to help you explore this issue.

How much autonomy do you have in your team? (Place and X on the line below)

<-->

Total Autonomy   No Autonomy

How much autonomy would you like to have in your team?   (Place and X on the line below)

<-->

Total Autonomy   No Autonomy

Do you on the whole feel you have too little autonomy, or too much?

What do you think the effects of this are upon your ability to deliver high quality care for patients?

Given what research findings indicate about the effects of greater autonomy and greater team integration on staff and patients respectively (see page 55.) how do you think the correct balance could be achieved in your team?

Write down one change that the team could make that would result in a better balance between autonomy and team integration? Discuss the ideas you came up with, with your colleagues.

Research Evidence about the impact of Autonomy on Team Performance

The idea that the whole team should be more than the sum of parts is at the heart of the thinking about teams (LaFasto and Larssen, 2002, Katzenbach and Smith, 2003). This does not mean that professional boundaries should be dissolved and generic health and social care professionals need to be created. It is more about developing a collaborative way of working in which the autonomous practice of each team member is enhanced (Arcangelo, 1996, Cashman et al., 2004, Zaccaro et al., 2001)

According to a study by Nancarrow et al. (2009) the level of autonomy professional staff perceived they had, has a direct relationship with whether or not they intend to leave their job in the near future. However, this study also shows that teams that are more integrated (and in which individual staff have less autonomy) have better patient outcomes overall.

Career autonomy is very important, particularly to professionally qualified staff. In teams where professional staff do not feel they are allowed enough autonomy and responsibility more staff want to leave the team. (Borrill et al 2005).

Having a range of different professionals involved brings different perspectives and skills to patient care; when intertwined, these different practice paradigms results in additional value for patients in terms of quality, cost, and satisfaction (Cashman et al, 2004).

The tension between greater collaboration and greater autonomy can be challenging. High levels of collaboration can be perceived by staff as a benefit when interdisciplinary teams are functioning well. However, in less well functioning teams reduction in individual autonomy and responsibility can be seen as a loss (Loxley, 1997).

One argument that is often put forward against team working is the issue of accountability. When services are not performing well lack of individual accountability can create confusion in roles, hide poor performance and indifference, and create problems in patients getting redress for poor care (Loxley, 1997). Significantly, in the UK, high-profile enquiries into failures in care have reported the need for clarity in identifying the responsibilities of individual team members (Baxter and Brumfitt, 2008).

If team working is seen as a reduction in individual responsibility among staff, this may be a worrying development. Shared decision-making, however, can be viewed as positive, expanding responsibilities and enriching roles. Studies indicate that patient safety (a reduction in clinical errors) can be associated with better team decision-making (Alonso et al., 2006)

Team Size

Teams come in all sorts of different sizes and structures. There is a lot of debate about the ideal size of a team. Can two people be a team?   Can 100 people be a team? And what are the potential advantages and disadvantages of different sized teams?

The next questions have been designed to help you to explore this issue. Read the research evidence of the impact of team size on team performance on page 57.

How many members are there in your team?

Does the size of your team have any effect on its overall performance? If so how?

Write down one change that your team might make to improve communication and coordination in a team of your size. Discuss your ideas with other team members.

Staff in smaller interdisciplinary health and social care teams often report that they are more satisfied than colleagues in larger teams. However, larger teams more often have better patient outcomes. Higher levels of team integration were related to decreased intention to leave the organisation and improved team member satisfaction. (Nancarrow 2009)

Researchers have consistently found that team size has an impact on performance (Lencioni, 2002, Katzenbach and Smith, 2003). Whilst it is difficult to put an absolute limit on team size, the figure of 5-7 is often put forward as the optimum size. Cohesiveness can become a problem when 10-12 members are exceeded. When groups get larger than 10-12 they tend to start splitting into subgroups (Mullins, 2008).

Organisations surveyed state anything from 4-15 as the optimum team size. It is difficult to communicate effectively face-to-face with more than 15. Conversely, if a team is too small with less than 4 members, there is not enough richness of experience, skills, or creative ideas among members to do the work (Shortell, 2005, Cane, 1996).

When a team gets too large it may take too long to get things done. This tends to result in heavy transactions costs—in terms of coordinating members, working without getting in each other's way, and trying to find a meeting schedule to suit everyone (Shortell, 2005).

Studies in health and social care have found that teams of 8-12 people are most effective in accomplishing their goals and that teams of 8 to 10 members was optimal for teams focused on quality improvement for chronically ill patients (Shortell, 2005).

The environment within which teams work can be important. Staff working in smaller centres commonly report a feeling of "family" as a benefit. Being physically close together creates less need for formalized structures to ensure clear team communication. People often meet each other informally and deal with business as it comes up. Working in larger interdisciplinary centres can cause confusion amongst team members about affiliation, particularly in new teams. In centres with 40 or more staff, consensus decision-making and coordinating actions effectively becomes difficult to achieve. People can become frustrated with lack of "air time", and it is a lot harder to make decisions through consensus and participation. As a result, staff can come to view staff meetings as a waste of time, and become anxious to get back to serving their clients more directly (Laiken et al., 2006).

A literature review by Xyrichis and Ream (2008b) found that six factors impact on interprofessional team working, namely; team premises; team size and composition; organisational support; team meetings; clear goals and objectives; and audit.

Team working

Calling a group of people a team does not necessarily make them one. It takes time and effort to build and maintain a team and conscious efforts by the members to integrate their work. The questionnaire below aims to help you to explore some of the main dimensions of team working.

Team Excellence Questionnaire

This questionnaire contains questions about your team. Indicate to what extent each statement is true or not of your team. Use the following scale:

Key:

1 = false   2 = more false than true   3 = more true than false 4 = true

		1	2	3	4
	There is a clearly defined need or goal to be achieved, or a purpose to be served-that justifies the existence of our team. (clear, elevating goal)	1	2	3	4
	We have an established method of monitoring individual performance and providing feedback.(results driven structure)	1	2	3	4
	Team members possess the essential skills and abilities to accomplish the team's objectives. (competent team members)	1	2	3	4
	Achieving our team goal is a higher priority than any individual objective. (unified commitment)	1	2	3	4
	We trust each other sufficiently to accurately share information, perceptions and feedback. (collaborative climate)	1	2	3	4
	Our team exerts pressure on itself to improve performance. (standards of excellence)	1	2	3	4
	Our team is given the resources it needs to get the job done. (external support and recognition)	1	2	3	4

(Larssen and LaFasto, 1989)

Compare your scores with colleagues. Were the scores you gave roughly in line with your colleagues? If your scores differed discuss the reasons why you scored the different statements differently.

Read the evidence on pages 60-62. Given your scores for these different statements, each of which refers to an important aspect of team working, write down one thing that you think the team could do to improve team working in your team?

Discuss your thoughts with colleagues?

In interdisciplinary health and social care teams, better team working and higher levels of team integration are both related to staff having a reduced intention to leave their job, and improved team member satisfaction (Nancarrow et al., 2009).

A literature review by (Xyrichis and Lowton, 2008) found that team structure and team processes are the two main factor that impact on interprofessional team working. Within these broad themes six key areas emerged: team premises; team size and composition; organisational support; team meetings; clear goals and objectives; and audit.

Four randomised controlled trials focused on team working or related factors. An intervention to improve ongoing coordination in a hospital based interdisciplinary team resulted in a reduction in length of stay and a significant difference in General Health Questionnaire score by patients, at three months (19.5/24, p = 0.02), but not at six. There was no difference found in primary outcome, but higher death/institutionalisation was reported in the control group (OR 3.8, 95% CI 0.8-23)(Bautz-Holter et al., 2002). An intervention aimed at improving interchangeability of roles found no differences in the first year of operation. However, in the second year year there were reductions in the: hospitalisation rate (p = 0.03), readmission rate (p = 0.03) and mean hospital visits (p = 0.003) in the intervention group. The differences were greatest where the nurse, and social worker were most satisfied with their working relationships. There was no difference in mortality over both years (Schraeder et al., 2001). A trial by Rubenstein et al. (1984) showed that patients treated by a multidisciplinary team in a geriatric unit had a lower mortality rate than controls. Further, stroke patients treated by multi-disciplinaryteams achieved significantly higher scores for functional and motor ability improvement that those who received traditional patient care (Wood-Dauphinee et al., 1984). The improvements were only significant for male patients however.

A team training intervention in stroke care found that stroke patients treated by staff who participated in a team training program more likely to make functional gains than those treated by staff receiving information only. There were no significant differences in length of stay or rates of community discharge (Strasser et al., 2008).

Research by Larssen and LaFasto (1989) identified eight characteristics that are consistently related to excellent team working.

Clear, elevating goal. High performing teams have both a very clear understanding of the goal that the team is trying to achieve, and think that this goal is worthwhile and important. Where teams were perceived to be performing ineffectively the problems were always to some extent goal related. Team efforts were unfocused; there were too many competing goals; the goals had become politicised: individual goals were taking priority over team goals.

Results-driven structure. The important thing about structure is not how much or how little, but that the structure of the team is appropriate for it to deliver its goals, or service whatever caseload a team has.

Competent team members. Team members should be selected on the basis that they are the people who are best equipped to achieve the teams objectives, or provide for the needs of the caseload the team has.

Unified commitment. This factor is most often missing in ineffective teams. However, it is quite difficult to describe what it is. It implies: putting needs of the group before personal ones; an intense

identification with the group; a sense of excitement and enthusiasm about the team and its work; a willingness to do anything necessary to help the team to succeed. Another term that might be used is team spirit.

Collaborative climate. The achievement of any team goal requires co-ordinated action. The element most consistently related to developing a collaborative team climate was trust. Trust has been found to have four elements.

- **Honesty** - integrity, no lies, no exaggeration;

- **Openness** - willingness to share, and a receptivity to information, and differing perceptions;

- **Consistency** - predictable behaviour and responses; and

- **Respect** - treating people with dignity and fairness (Larsson and LaFasto, 1989).

Standards of excellence. A standard can be defined as pressure to achieve a defined level of performance. In terms of teams, standards should not be thought of simply in terms of outcome performance (e.g. reducing hospital re-admissions). Standards might refer to the level of technical knowledge, skill, and ability that is required in particular roles; the level of initiative and effort team members are expected to demonstrate; the way people are expected to treat each other; or, how absolute deadlines are met. Each individual within a team will have their own personal standards, developed from their life experiences. To create a high performing team, it is important that individual standards are discussed amongst the team and certain internal standards are agreed by team members. Often standards are imposed on teams externally. For these to be effective the team needs to fully understand the standards and the reasons for them. They must also understand the rewards for success and the consequences of failure.

External support and recognition. External support and recognition seems to be more caused by team success than a cause of it. Team members identify it more often when their team is not functioning well, but not so much when their team is performing well. Typical markers for the presence of external support and recognition include: the team being given the resources it needs to achieve its goals; the team being supported by those external stakeholders who are capable of contributing to the team success: the team being sufficiently recognised for their accomplishments; a clear reward and incentive structure in place which is viewed as appropriate by team members and is tied to performance.

Principled leadership. (See the section on Team Leadership)

Other research evidence tends to support the framework developed by Larsson and LaFasto (1989).

There is a link between team working and patient mortality. One study found that in hospitals where more than 60% of staff worked in teams, patient mortality was 5% less than expected (Borrill et al 2005).

Positive and significant predictors of team cohesion and team effectiveness in healthcare are Leadership, communication, coordination, and conflict management. Further, teams are seen to be more effective by older team members: - the longer the team has worked together, the more ethnically

diverse the membership of the team is, and the more this diversity is reflected in the patient population; and the greater the availability resources. (Temkin-Greener et al., 2004)

"Teams work most effectively when they have a clear purpose; good communication; co-ordination; protocols and procedures; and effective mechanisms to resolve conflict when it arises"
(CHSRF, 2006b: i).

"Successful interdisciplinary teams recognize the professional and personal contributions of all members; promote individual development and team interdependence; recognize the benefits of working together; and see accountability as a collective responsibility". (CHSRF, 2006b: i)

Gaining a more holistic view of a person is beneficial to staff's own profession-specific work. A shift from a more medical model view of care to a more rehabilitative, or a more patient-centred model of care, is often associated with better team working (Hall and Weaver, 2001)

Faster processing of referrals so care is provided more speedily, was identified by staff as a major benefit of team work (Baxter and Brumfitt, 2008). Evidence suggests that early rehabilitation produces better outcomes (Department-of-Health, 2005).

Feiger and Schmitt (1979) found that when patients who received treatment from groups of professionals collaborating together gained more benefits than those treated by professionals working in isolation. Further, the least hierarchical teams achieved the best patient outcomes overal

Effective team care for chronic illness often involves professionals outside the core team working together in a unified way (Wagner, 2000).

Team Integration

Each box contains 3 statements. Read each statement and choose the one that, on the whole, most effectively describes your team. Then write the number of the statement in final column (e.g. if for question A. you decide statement number 2 most effectively describes your team, score 3 in the last column.). (NB This tool and the descriptions included are adapted from the paper by Thylefors et al. (2005)

A	1) Team roles are specialised and everyone concentrates on her or his own tasks. 3) Team roles are specialised, but everyone is expected to interact. 5) Although team roles are specialised, everyone must also be prepared not only to complement, but to replace each other when necessary.	
B	Tasks are usually: Performed in a determined sequence; 3) Partly interdependent and must be coordinated; 5) team members as well as their tasks are interdependent;	
C	1) Coordination is based on supervision or standardisation. 3) Everyone has to coordinate their activities. 5) Coordination is achieved by direct interaction, flexibility and improvisation.	
D	1) Tasks are specialised and only those with a special professional education are allowed to perform the task. 3) Everyone must be prepared to adjust to the task. 5) Everyone must be prepared to adjust to the strengths and weaknesses of others.	
E	1) The team leader functions as a traditional manager. 3) The team leader functions as a "coach" or facilitator. 5) Team leadership varies with the situation; the team is largely self regulating.	
F	1) You do your job the best way you know. 3) You do your job and cooperate with your co-workers. 5) You do your job in an interactive way and are ready to make continuous adjustments.	
	TOTAL SCORE	

Results

The questionnaire asks a number of statements designed to find out about the working style of your team. The working style of health teams that include a range of professionals working together can be represented on a continuum as seen below.

Multidisciplinary   Interdisciplinary   Transdisciplinary
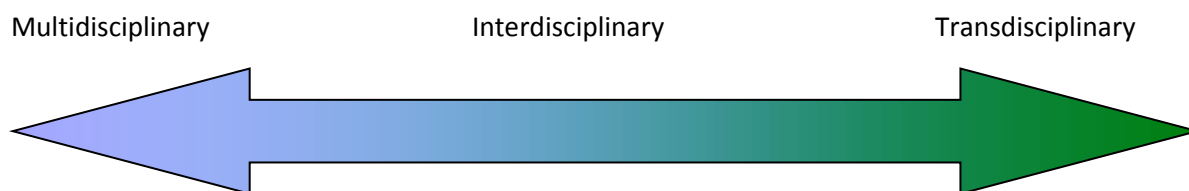
Scores 6-11 - Multidisciplinary working

"In multidisciplinary teams members of different professions or disciplines assess or treat a client/patient independently and share only information with each other (Sorells-Jones, 1997). The team is focused on the task, not the collective working process, and contributions are made either in parallel or sequentially to each other with minimum communication. Each contribution stands alone and can be performed without the input from others. These independent contributions have to be co-ordinated. In healthcare, doctors have traditionally taken this responsibility." (Thylefors et al., 2005: 104)

Scores 12-20 - Interdisciplinary working

"As opposed to multidisciplinary work, in interdisciplinary team's successful outcomes can only be accomplished through the interactive effort and contribution of the disciplines involved; this implies a high level of communication, mutual planning, collective decisions and shared responsibilities (Day, 1981, Sicotte et al., 2002). To allow for optimal and holistic management of the client's problems, everyone involved in the process must take everyone else's contribution into consideration." (Thylefors et al., 2005: 104)

Scores 20-30 - Transdisciplinary working

The transdisciplinary team operates at the opposite end of the continuum compared to the multidisciplinary team. The team uses an integrative work process and disciplinary boundaries are partly dissolved (Zeiss and Steffen, 1996). The characteristic attributes of a transdisciplinary approach are role extension (increase of discipline-specific knowledge), role enrichment (incorporating knowledge of the other disciplines), role expansion (transmitting one's own expertise to other team members), role release (blurring traditional discipline boundaries) and role support (support of, and feedback to, others on the implementation of skills). (Thylefors et al 2005: 104). Sometimes there is a danger in transdisciplinary teams that, because of role blurring, team members can lose sight of the valuable contribution of expertise or the role of other disciplines and not use the available expertise in full (Mariano, 1999).

Which type of team do your scores indicate you work in (Multi-disciplinary / Interdisciplinary / Transdisciplinary)?

What are the pros and cons of working in your type of team?

Do you have a preference for a particular team working style and why?

Read the evidence on page 66. Discuss your findings with your colleagues. Did they see your team in the same way?

The more team characteristics resemble those of the transdisciplinary team, the higher the perceived efficiency by team members. Members of transdisciplinary teams more often report that their team climate is characterized by team spirit, trust and openness (Thylefors et al 2005).

Greater integration accounts for improvements in patient care and organizational effectiveness. Further; collaboration, conflict resolution, participation, and cohesion are most likely to influence staff satisfaction and perceived team effectiveness (Lemieux-Charles and McGuire, 2006, Vroom and Yetton, 1973).

The level of team cohesion is an important predictor of team effectiveness (Vinokur-Kaplan, 1995).

Cohesive teams have five characteristics: clear goals with measurable outcomes; clinical and administrative systems; division of labour; training of all staff members; and effective communication (Grumbach and Bodenheimer, 2004).

A key predictor of the overall effectiveness of a team are clarity of team objectives and commitment to them. Further, effective teams pay attention to processes such as, participation, quality, and support for innovation (Poulton and West, 1999).

Having team members who have been together over many years provides stability and an opportunity for the team to develop over time (Laiken et al., 2006).

Working effectively in a team requires the possession of knowledge, skills and attitudes that allow individuals to support and build on the work of other team members, get along with people generally and manage conflict (West and Slater, 1996).

Good working relationships are built and maintained by team members understanding and acknowledging each other's skills and roles. Agreeing processes for resolving conflict assists identification and management of predictable problems (Borrill et al. 2000; West & Slater 1996).

Multidisciplinary activities such as audit, pilot projects, and joint education and training can contribute positively to strengthening group processes (Pritchard and Pritchard, 1994).

Team Meetings

You might have noticed that a lot of the things that are connected to excellent performance are related to how well the team communicates, whether it coordinate its efforts effectively, or is able to resolve disagreements and conflicts. Although we often have mixed feelings about meetings there is a lot of evidence that they are very important mechanisms for ensuring good communication and coordination of tasks.

How often does you team meet together? What is useful about these meetings? What is unhelpful?

How often do you take part in case conferences? What is useful about them? What is unhelpful?

Read the evidence about the impact of team meetings on the performance of teams on pages 68-69. Name one thing your team could do that could improve team meetings. Discuss it with your colleagues.

There is a wide range of evidence about the potential impact of team meetings on performance.

Protected time for teams to meet on a regular basis, both for task accomplishment and to acknowledge successes, or simply to celebrate and socialize together is important. Team members working directly with each other should meet regularly on a day-to-day, or week-to-week, basis. Larger groupings of staff should meet once a month for updates and information sharing, to ensure team coordination (Laiken et al., 2006).

Teams which had regular team meetings had higher overall levels of satisfaction and produced better patient outcomes overall (Nancarrow et al., 2009).

Team training and development activities, coupled with dedicated time for team meetings, resulted in team members' expressing values consistent with high functioning teams (Cashman et al., 2004).

A Cochrane Review found that daily ward rounds have a positive impact on length of stay and total charges and resulted in improved prescribing of psychotropic drugs in nursing homes. It also found that multidisciplinary case conferences conducted by videoconference resulted in a decreased number of case conferences per patient and shorter length of treatment. No differences in frequency of service, length of conference, or the number of communications between health professionals were recorded in the notes (Zwarenstein et al., 2009).

Bennett-Emslie & McIntosh (1995) isolated frequency of team meetings as the single most critical factor that fostered collaborative team work within general practice in the UK.

Borrill and colleagues (2000) highlighted the importance of regular team meetings, finding them to be associated with effective team work and with greater levels of innovation.

Rutherford & McArthur (2004) similarly reported that team meetings were particularly important for effective working, contributing to a breaking down of professional barriers and improved interprofessional communication. Enhanced communication developed through effective team meetings has been identified as an important facilitator for effective team working. Lack of communication was reported as causing misconceptions about each profession's roles and responsibilities (Xyrichis and Lowton, 2008).

Molyneux (2001) also reported positive results of team meetings, where the team considered meetings to be of high value.

When barriers to team work are eradicated, such as geographical separation and different employers, community rehabilitation teams are able to achieve high levels of team work. However, flexible working arrangements proved a much more difficult barrier for teams to resolve (Griffiths et al., 2004).

Team conferences provide an opportunity for all members of rehabilitation teams to report patients' progress and establish their rehabilitation goals (Gibbon, 1999). This sharing of knowledge and information benefits both staff and patients (Baxter and Brumfitt, 2008)

There is a link between the creation of shared (team) knowledge and improved team performance (Hoopes and Postrell, 1999).

Sometimes team conferences do not discuss alternative intervention plans or rehabilitation goals, but rather are used just to disseminate decisions. Even where team conferences were only used to effectively disseminate decisions they still gave rise to a sense of team collaboration (Gibbon, 1999).

Team meetings were also recognised as a key mechanism for team building, which is an important priority and they can be used in a variety of ways to achieve this (Baxter & Brumfitt, 2008).

Despite all the positives there are real pressures that act against staff meeting regularly.

Staff do not generally see team meeting time as "real work", but as an "add-on" to their working day. Because they have a limited number of hours at their disposal, and growing lists of clients waiting for attention, they often struggle with this dilemma and report making difficult choices between time for patient care and team working time (Baxter & Brumfitt 2008).

"Insufficient time for formal and informal meetings of the team, and the contractual obligations of some important off-site team members, can lead to individual team members not having the appropriate level of contact to fulfil their own and the team's needs. Team work takes time because each new team member multiplies the need for communication and co-ordination" (RCGP, 1995: 15).

Supportive organisations value time in meetings as legitimate and a critical part of effective team-work . Mechanisms for promoting regular team meetings such as: encouraging meetings during work hours, providing needed support and resources, booking blocks of meetings well ahead to allow part-timers and others to schedule their attendance, defining tasks so that staff in meetings see them as contributing in tangible ways to their work with clients; can help staff to see meetings as important for the high performance of the team (Laiken et al, 2006).

Significantly, Wiles & Robison (1994) found a low prevalence of regular team meetings with most professionals only meeting when problems needed to be discussed.

Similarly, Field & West (1995) found that only one of six GP practices set aside time for regular team meetings. Time pressure was commonly given as the reason for this.

Innovation

We have included a section about innovation in this workbook even though research does not clearly indicate that it is something that promotes effective team work. However, what research does indicate is that the most effective teams usually have high levels of innovation. The following questions are designed to help you to consider how innovative your team is.

How often does your team come up with new ideas to solve ongoing problems or to improve your service generally?

What things do you think would support the team in being creative?

Read the evidence about team innovation on page 71. How do you feel your team could become more innovative in its approach to delivering and developing the service?

Effective team working consistently predicts high levels of innovation. Effective team leadership also predicts innovation (West et al., 2003).

Clarity of leadership is vital for health care teams in particular, and teams in general, whose role requires innovation (West et al 2003).

Interdisciplinary teams are complex as the members are trained in different disciplines and use different tools, frameworks and approaches to assist the patient. Working in interdisciplinary teams has been found to change the assumptions, behaviour and treatment practices of healthcare professionals over time (Drinka and Clark, 2000).

Borrill and colleagues (2000) highlight the importance of regular team meetings, for both effective team work and greater levels of innovation.

Clarity of leadership

There is a clear indication that the most important things for effective interdisciplinary team working is having effective team leadership. Much of the leadership role in interdisciplinary teams is shared by members of the team, as at different times any one person or discipline may have the knowledge or information required. Sometimes, as a result of this necessity for shared leadership, there can be confusion about who is really in charge. The effects of this can be severe. Read the evidence on page 73 then answer the following questions.

How clear are you who your team leader is?

Is the person with the formal role of leader usually the person who leads day to day?

To what extent would you say that leadership is shared within your team?

Are you sometimes confused as to who is leading the team? If so, what are the effects of this confusion (choose a concrete example and write it down)?

Interdisciplinary health and social care teams with a specific team leader had higher levels of staff satisfaction than teams where the leadership role was split. (Nancarrow et al., 2009)

Clarity of leadership is vital to high performance health and social care teams. According to West et al. (2003) teams who were clear about who their leader was had clear team objectives, high levels of participation, commitment to excellence, and support for innovation. Health care teams who were not clear who their team leader was, performed significantly worse and suffered from higher patient mortality rates. Avoiding conflict over leadership especially in newly formed teams is important (West and Markiewicz, 2004).

"In geriatric interdisciplinary teams physicians often "saw themselves as the captains" of the teams. In these situations the degree to which other professionals had input varied and nonmedical input, such as that from social workers, tended to be underappreciated. Decisions were not usually made collectively". (Williams et al., 1999: 227)

In interdisciplinary teams, leadership is often shared and all team members carry responsibility for team process and outcomes. In practice the informal leadership roles shift according to the situation, the expertise required and the nature of the problem to be solved. (McCallin, 1999, Wilson and Gleason, 2001).

However, according to McCallin shared leadership occurred only in smaller teams privileged in being free to choose all team members. (1999a, unpublished doctoral dissertation)

"Despite evidence supporting shared leadership models there is also strong evidence to suggest that interdisciplinary teams still need an overall team leader to manage the different disciplines, coach colleagues in the art of shared leadership, look after the team, and to manage processes" (Maister 1993: 212).

Interdisciplinary teams need an experienced professional as leader. Someone well respected by colleagues across all disciplines; a people manager; a person who understands the pressures of work, and the difficulties of working with colleagues who move in and out of the team; a colleague who is interested in each individual and is able to question, probe, and gently challenge an individual's contribution to the team in a non-threatening way (Maister, 1993).

The team leader's goal is to *"maintain an informal, democratic atmosphere"* (Schmitt and Carroll, 1978: 203).

"Effective team functioning depends on compromise, consensus building and role flexibility". (Krueger, 1987: 133)

Centralised vs. distributed leadership (self-managing teams)

From the previous section you might have come to the conclusion that leadership in an interdisciplinary team is quite complex. Most of the time leadership is shared and people move in and out of informal leadership roles, often when their expertise is most required by the team to deal with a particular case or problem. This represents a paradox though as this distribution and sharing of leadership can only work if there is a strong team leader in charge of who facilitates and manages the process.

The following questions are designed to help you to think about how much leadership is distributed (or centralised) within your team.

Examine the list below, in which various leadership styles are described. Choose the leadership style, which on the whole describes the preferred way of working of your team leader.

AI: Our Team leader solves the problems and makes the decisions based on the information available to him/her.

AII: Our Team leader seeks information from subordinates before making the decision.

CI: Our Team leader shares the problem with team members individually and obtains their suggestions and opinions. They then make their decision, which may or may not reflect our input.

CII: Our Team leader shares problems with the team together and obtains their suggestions and opinions. They then make their decision, which may or may not reflect our input.

GII: Our Team leader shares problems with the team, together the team generates solutions and evaluates alternatives, the solution that has the support of the entire team is selected and implemented.

The three letters A, C and G stand for Authoritarian, Consultative and Group (participative) (Adapted from Vroom and Yetton, 1973).

What might be the pros and cons of each leadership style ?

What do you feel is the dominant leadership style in your team?

Read the evidence about leadership styles on pages 76-77. Do you feel on that the balance between centralised and distributed leadership within your team is about right?

How could the balance be improved?

"A self directed work team is a natural work group of interdependent employees, who share most, if not all, the roles of a traditional supervisor" (Hitchcock and Willard, 1995: 4).

According to Moorhead (1998) over-centralised team leadership can lead to "groupthink"

According to McCallin (2003) the concept of stewardship mirrors many of fundamental values of interdisciplinary team work.   Stewardship is based on partnership, shared responsibility and colleagueship. It is a set of principles and practices which according to Block (1996) promotes accountability over and above control or compliance.

Another, leadership model that is very relevant to interdisciplinary Health and Social Care teams and incorporates Block's concept of Stewardship is that of 'Servant Leadership" (Neill et al., 2007). According to Spears (2004) Servant Leadership consists of the following: -

Listening. Leaders have traditionally been valued for their communication and decision-making skills. Within servant-leadership communication skills are founded on a commitment to listening deeply to others.

Empathy. The servant-leader strives to understand, accept and empathise with others.

Healing. Greenleaf identified that however much people have been damaged by emotional hurts that they all have the urge within to make ourselves whole. He asserted that a key role of servant leaders was to heal both themselves and others, to *"help make whole"* (Greenleaf, 1991: 12).

Awareness. Servant-leaders not only have a strong sense of general awareness to identify leadership opportunities and understand the ethical dimensions of issues, they are also self-aware. The combination of the two helps servant leaders to develop a holistic understanding of any situation.

Persuasion. Servant-leaders primarily rely on persuasion rather than positional authority to convince others rather than coerce compliance.

Conceptualization. Servant-leaders are innovators. They are able to think beyond day-to-day realities to create new solutions.

Foresight. Through understanding lessons from the past, the current situation, and the future consequences of particular decisions servant-leaders are able to make a "*better than average guess about what is going to happen in the future* " (Greenleaf, 1991: 16)

Stewardship. Stewardship is defined as holding something in trust for another (Block, 1996). Greenleaf (2003) viewed that a significant role of all CEO's, staff and stakeholders is to hold their institutions in trust for the greater good of society.

Commitment to the growth of people. Servant-leaders believe in the principle that all people have value and that this value goes beyond their instrumental value as workers. They understand that *"the secret of institution building is to be able to weld a team of such people by lifting them up to grow taller than they would otherwise be"* (Greenleaf, 1991: 14).

Building community. Greenleaf asserted that large institutions have damaged communities and become the biggest influence of human lives, and that a primary role of the servant-leader was rebuild viable communities, both within institutions and in society (Greenleaf, 1991).

Quality of Leadership

As you can imagine if you have worked through the previous sections, the team leadership role in an interdisciplinary healthcare team requires someone with a high level of people skills, as well as a high level of broad expertise about the roles of all the different disciplines in the team.

The following exercise is designed to help you to think about the dimensions of effective team leadership.

Collaborative Team Leader Questionnaire

This questionnaire contains questions about the leadership within your team. Indicate whether you feel each statement is true or not true of your team. Use the following scale:

Key:

1 = false   2 = more false than true   3= more true than false   4 = true

1.	If it is necessary to adjust the team's goal, our team leader makes sure we understand why. (Focus on the goal)	1	2	3	4
2.	Our team leader creates a safe climate for team members to openly and supportively discuss any issue related to team success. (Ensure a collaborative climate)	1	2	3	4
3.	Our team leader looks for and acknowledges the contributions made by individual team members. (Build confidence)	1	2	3	4
4.	Our team leader understands the technical issues we must face in achieving our goal. (Demonstrate sufficient technical know-how)	1	2	3	4
5.	Our team leader does not dilute our team's effort with too many priorities. (Set priorities)	1	2	3	4
6.	Our team leader is willing to confront and resolve issues associated with inadequate performance by team members. (Manage performance)	1	2	3	4

(Adapted from Larssen and LaFasto, 1989)

Ask a colleague to compare scores. Were the scores you gave roughly in line with your colleagues? If you find there are differences discuss the reasons why you scored the different statements differently.

Read the evidence about quality of leadership on team performance on page 79. Write down 3 things your team could do to develop leadership strength across the important areas of your work?

Discuss your ideas with your colleagues.

Effective leadership acts to increase the motivation and satisfaction of staff, influences them to buy into the mission/goals of the organisation or team in which they work and aligns their personal development goals to that of the organisation. Increasing motivation, satisfaction and goal directedness, generally will increase the amount of effort that workers make and this in turn will generally improve organisational/team performance (Bass and Avolio, 1994).

There are also other benefits. Quality of leadership has also been found to have a significant effect on levels of absenteeism (Luz and Greene, 1997).

Effective team leadership can influence performance by enhancing the level of confidence felt in the group or team (LaFasto and Larssen, 2002 pp. 148).

Members of primary health teams in England rated their effectiveness more highly when they had both strong leadership and high involvement of all team members (Ross et al., 2000). As discussed previously, this seems somewhat paradoxical, but the evidence points convincingly to the fact that shared leadership prospers best where there is a strong team leader who can create an appropriate climate for it.

Teams are much more effective when they have strong leadership and administrative support, and operate within an organisation that supports team work (CHSRF, 2006b).

Team leadership training, which focuses on practical aspects of leadership (such as establishing common goals) rather than psychological aspects (such as establishing a climate of safety and participation) has shown positive results (CHSRF, 2006b).

The team leader has responsibility to develop team processes (for example, clarity of roles and support for the team) and creates favourable performance conditions for the team (Hackman, 2002). Further, the leader must recognise the importance of setting clear tasks, and ensuring the right skill mix and level of diversity in the group, when building a team (West and Markiewicz, 2004, Hackman, 2002)

Effective interdisciplinary team work "*requires sound leadership, effective team management, clinical supervision and explicit mechanisms for resolving role conflicts and ensuring safe practices. No one profession should hold a monopoly on leadership*" (Rosen and Callaly, 2005: 234).

A number of randomised controlled trials have found that leadership has significant effects on health and social care outcomes. A study on mental health care managers found that effective leadership was associated with patients faring significantly better ($P < 0.05$) for *"continuation of antidepressant treatment, depressive symptoms, remission of depression, physical functioning, quality of life, self efficacy, and satisfaction with care at 18 and 24 months"* (CHSRF, 2006a: 6). Benefits included less depression, better physical functioning, and an enhanced quality of life (Hunkeler et al., 2006 in CHSRF 2006a).

Saltvedt et al. (2002) found that more effective leadership of joint meetings was associated with: median length of hospital stay significantly longer in GEMU than control settings; an average of 3

diagnoses were made in GEMU group compared to 2 diagnoses in control;   mortality was lower in GEMU group during first year compared to control group, significantly so for 3, 6, 9 months period.

Birks and Crotty (2004) found that more effective leadership of case conferences was associated with Medication appropriateness improvement (MAI); a significant reduction in MAI for benzodiazepines. Resident behaviours were unchanged after the intervention however, and improved medication appropriateness did not extend to other residents in the facility.

Liberman and colleagues (2001) emphasise effective leadership as a key determinant of the efficacy of communication among team members and overall team success.

Currie and Harvey (2000) established a dependency between leadership and the subsequent success of clinical pathways.

Part Three - Evaluation tools for capturing and measuring success

Introduction

In today's Health and Social Care system it is no longer enough to simply deliver services. There is an increasing demand to be able to measure the impact of the service we are delivering. Sometimes this issue feels alien to us, because it is not directly about delivering excellent services to clients, and it represents a different area of expertise to that which we are trained in.

Nevertheless, a fundamental question exists. If we can't measure what we do, how do we know we are making any difference to our patients? Whilst we can have confidence in our expertise and are able to articulate the impact we have on clients, this form of evidence alone is not enough. It is therefore important that we have robust mechanisms to measure our impact.

It is also helpful to know if we make changes to our service, whether and how those changes have effected service delivery and outcomes. Again, robust ways of measuring service delivery and outcomes is the key to success.

A final issue is that it is increasingly likely that we will be asked to tender to provide services to solve difficult commissioning issues. An example may be reducing the number of re-admissions in our area. Having robust performance data that shows how we can deliver effective outcomes to the clients being targeted can assist us in developing powerful and persuasive business cases to win funding for our service.

Often when we work with teams we are made aware that they are already being asked to collect large amounts of data. However, all too often teams do not see results from the analysed data. Often the data teams are being asked to collect attempts to measure things that are related to policy change, but it does not measure important things that the team need to know, such as the outcomes of the care they are providing to clients.

Finally, we see that many of the measures teams are asked to use have not been well developed and as a result are unlikely to measure what they claim to.

Therefore, this part of the IMT will therefore discuss how you can set up systems to effectively measure the performance of your service and the impact of changes in the service, through implementing the IMT intervention in particular.

We will also suggest some tools for you to use that have been well developed and that we know provide valid and reliable measures of important team process and patient outcome factors.

What things do you need to measure?

Patient data

Perhaps the most important thing for a service to be able to measure is the impact they have on patients. In some areas of health and social care beneficial outcomes may be clear and easy to measure, but in the vast majority of areas measurement of outcomes is challenging. In particular, intermediate care and community based rehabilitation teams are increasingly working with older patients who have chronic, multiple, long term conditions. Choosing the right things to measure and the best tools to measure them with is important. Below are some of the tools that we have used and know to be accurate, reliable and valid measures. For the IMT intervention these tools have been all put into one form call the Client Record Pack (CRP). However, they can be used separately if appropriate.

Basic Demographic Data

It is important to capture some basic demographic data about your patients, including:

Age:
Sex:
Source of referral:
Current Living Arrangements (at referral):

Knowing about the average age, age range; proportion of males to females; where you are getting your referrals from; and how independently they have been living prior to referral gives important information. It enables you do things like profile the type of patients you are getting, or find out if how often particular agencies or services are referring to you.

Level of Care Required

It is desirable to be able to understand the level of care that patients require when they arrive and the level of maintenance care they need after discharge. The eight levels of care tool allows you to do this in a way that can be compared across all patients independent of their particular conditions.

What is the Eight Levels of Care tool?

The Eight Levels of Care are based on Enderby and Stevenson's Eight Levels of Care model (Enderby and Stevenson, 2000, Stevenson, 2001).

Work was undertaken in 1999 in Sheffield by various intermediate care and rehabilitation stakeholders to identify gaps in the system and to identify points where intermediate care could be offered in a way more appropriate to a person's needs.

The group decided to consider people's needs and where they might best be met rather than adopting the more common approach of fitting people into services already provided.

Eight broad categories of care were defined in order to clarify the needs of people with disabling conditions. The levels of care range from Level 1 'client needs a prevention and maintenance programme' to Level 8 'client needs rehabilitation for complex profound disabling condition'.

The levels of care tool has since been used in local evaluations of community rehabilitation and intermediate care (Nancarrow et al., 2005).

How and when do I administer the tool?

Within the client record pack you will find a section titled 'Level of Care' in both the admission and discharge sections.

You need to assess the client against the eight levels of care once on admission and once on discharge.

This involves placing a tick or cross in <u>one</u> of the boxes on the page that best describes the client's needs.

For each level, there are specific aims that should reflect the level of client need. For example, at level 5 *'client needs intensive rehabilitation'* the client's aims are: -
- Change from dependent to independent;
- Reduce level of dependency on carers;
- Achieve maximum level of function; and/or
- Resolve acute disabling conditions

Whereas at level 6 *'client needs specific treatment for individual acute disabling condition'* the aim is: -
- Target specific treatment by one profession
- Alleviate or reduce specific Impairment / Activity

Where can I read about the tool?

If you want further information you could read: **Enderby and Stevenson (2000). What is intermediate care? Looking at needs.** *Managing Community Care*. **8 (6): 35-40.**

Level of care	Aim of this level of care
Client does not need any intervention	
Patient needs prevention / maintenance programme	• Prevent physical and psychological deterioration • Prevent loss of independence • Promote psychological well-being • Encourage healthy living • Promote positive attitude to independence
Client needs convalescence	• Encourage improvement and/or maintenance of independence • Improve recuperation • Wait for aids adaptations • Wait for family adjustment support • Adjust to new circumstances
Client needs slow stream rehabilitation	• Provide watchful waiting • Provide assessment/observation • Provide non-intensive rehabilitation/mobilisation • Provide confidence • Actively encourage, extend and facilitate increased speed of recovery • Provide support programme which is being carried out by Client and carers
Client needs regular rehabilitation programme	• Provide rehabilitation to maintain steady and measurable progress • Improve expected recovery trajectory
Client needs intensive rehabilitation	• Change from dependent to independence • Reduce level of dependency on carers • Achieve maximum level of function • Resolve acute disabling conditions
Client needs specific treatment for individual acute disabling condition	• Target specific treatment by one profession • Alleviate or reduce specific Impairment/Activity
Client needs medical care and rehabilitation	• Actively treat medical condition in order to prevent/modify deterioration or secondary sequelae whilst enabling Client to improve/maintain independence • Appropriately manage medical condition whilst Client undergoing multidisciplinary rehabilitation
Client needs rehabilitation for complex profound disabling condition	• Provide rehabilitation as part of long term management of condition • Maximise level of function, prevent secondary disabling condition and improve quality of life.

- Provide particular provision of services related to those with low incidence specialised cognitive and physical disorders

The Eight Levels of Care as it appears in the Client Record Pack

Level of Care: Please tick the level that best describes the client's needs **(tick only one)**

0	Client does not need any intervention		00
1	Client needs prevention / maintenance programme		01
2	Client needs convalescence / respite		02
3	Client needs slow stream rehabilitation		03
4	Client needs regular rehabilitation programme		04
5	Client needs intensive rehabilitation		05
6	Client needs specific treatment for individual acute disabling condition		06
7	Client needs medical care and rehabilitation		07
8	Client needs rehabilitation for complex disabling condition		08

Enderby P & Stevenson J (2000). What is Intermediate Care? Looking at Needs. Managing Community Care 8(6): 35-40

Case study using the Levels of Care

Mrs J fell in her home and was taken to Accident and Emergency by ambulance. Although she did not sustain any serious injuries, an intermediate care service assessed her in A&E and felt she was not safe to return home. The team transferred her to an intermediate care bed in a local nursing home.

Mrs J lost confidence in performing activities of daily living and walking as a result of the fall but felt her independence had been deteriorating for some time prior to the fall.

The occupational therapist who assessed Mrs J when she was admitted to intermediate care felt she required assessment and observation, non-intensive rehabilitation/mobilisation and confidence building => Admission Level of Care 3 'client needs slow stream rehabilitation'.

When Mrs J was ready to be discharged home she had re-gained confidence in her walking and ADLs however it was felt she required ongoing rehabilitation with another team to ensure she maintained her current level of independence => Discharge Level of Care 1 'client needs prevention/maintenance programme'.

Therapy Outcomes

It is essential to know what the outcomes of your therapeutic care plan have been for the patient, in a way that can be compared across all the clients you deal with. Again this needs to be independent of the particular conditions they have.

What is the Therapy Outcome Measure Tool?

The TOM was designed to be a simple, reliable, cross-disciplinary and cross-client group method of gathering information on a broad spectrum of issues associated with therapy/rehabilitation. It is a reliable measurement tool for physiotherapists, occupational therapists, speech and language therapists and rehabilitation nurses (Enderby et al., 1998).

The TOM allows therapists to describe the abilities of a patient in four domains based on World Health Organisation definitions (Enderby et al., 2006, Enderby and John, 1997, Enderby et al., 1998):

Impairment	Dysfunction resulting from pathological changes in system
Activity	Consequence of impairment in terms of functional performance (disturbance at the personal level)
Participation	Represents disadvantages experienced by the individual as a result of impairment and disabilities.
Wellbeing	Reflects interaction with and adaptation to the individual's surroundings.

How do I administer the TOM?

A rating from 0 to 5 is made on each domain, where a score of 0 is severe, 3 is moderate and 5 mild. For example a score of 0 for 'Activity' represents a patient who is totally dependent/unable to function; a score of 3 for 'Impairment' represents a patient who has a moderate dysfunction resulting from pathological changes; a score of 5 for 'Participation' represents a patient who is integrated and able to maintain their expected different roles in society, is valued by others, and exercises choice and autonomy (Enderby and Stephenson, 2000, Enderby et al., 2003). A score of 0.5 or ½ a point may be used to indicate if the patient is slightly better or worse than a descriptor.

When do I administer the TOM?

TOM should be administered at the commencement of intervention when assessment is complete, and again at discharge. This allows you to measure patient change over time.

Further information

The following book gives detailed information about the TOM.

Enderby, P., John, A., Petherham, B. (2006) Therapy Outcome Measures for Rehabilitation Professional, Chicester, John Wiley and Sons.

Training courses are also available for use of TOM .

Please contact:

> Professor Pam Enderby,
> Rehabilitation and Assistive Technologies Group
> School of Health and Related Research
> University of Sheffield
> Regent Court
> 30 Regent St
> Sheffield S1 4DA

For your reference we have included detailed descriptions of each TOM domain for the adapted TOM scale 'complex and multiple difficulty' on the following pages.

TOM adapted scale 18 - complex and multiple difficulty*

Impairment

0   No purposeful active movement, severe abnormality of muscle tone and patterns of movement, sensory loss, may have severe fixed deformities, severe respiratory difficulties. Presence of pathological reflexes.

1   Grossly abnormal muscle tone, occasionally some voluntary movement towards stimulus, some contractures, some pathological reflexes, sensory impairment, severely restricted range of movement, frequent respiratory difficulties.

2   Altered muscle tone, some purposeful active movement. Some abnormal primitive reflexes. Some joint contractures, may have sensory impairment.

3   Some useful strength, but abnormal muscle tone, co-ordinates movement without accuracy, requires large stable base and low centre of gravity, moderate sensory impairment.

4   Slight abnormality of strength, muscle tone, range of movement, minimal involuntary movements. Slightly impaired neurology with mild weakness or in-coordination.

5   Age appropriate tone, strength, range of movement and co-ordination.

Activity

0   No purposeful active movement, totally dependent, requires full physical care and constant vigilant supervision. May have totally disruptive and uncooperative behaviour. Dependent on skilled assistance.

1   Bed/chair bound but unstable to sit independently. Some very limited purposeful activity. Needs high level of assistance in most tasks. Some awareness, some effort and recognition to contribute to care. Dependent on skilled assistance.

2   Head and trunk control. Limited self help skills. Initiates some aspects of ADL. Transfers with one, mobilises with two. Requires physical and verbal prompting and supervision for most tasks and movements. Participating in care and engaging in some structured activity. Dependent on familiar assistance.

3   Transfers or walking requires supervision or help of one. Undertakes personal care in modified supported environment. Appropriately initiating activities, needs assistance or supervision with unfamiliar or complex tasks. Initiates activities appropriately.

4   Carrying out personal care and tasks but is less efficient, clumsy, requires extra time or may need encouragement, uses memory prompts and other aids effectively. Minimal or occasional assistance required for some complex or unfamiliar tasks.

5   Age appropriate independence.

Participation

0   Unable to fulfil any social/educational/family role. Not involved in decision making/no autonomy/no control over environment; no social integration.

1   Low self-confidence/poor self esteem/limited social integration/socially isolated/contributes to some basic and limited decisions. Cannot achieve potential in any situation.

2   Some self-confidence/some social integration/makes some decisions and influences control in familiar situations.

3   Some self-confidence; autonomy emerging. Makes decisions and has control of some aspects of life. Able to achieve some limited social integration/educational activities. Diffident over control over life. Needs encouragement to achieve potential.

4   Mostly confident; occasional difficulties integrating or in fulfilling social/role activity. Participating in all appropriate decisions. May have difficulty in achieving potential in some situations occasionally.

5   Achieving potential. Autonomous and unrestricted. Able to fulfil social, educational and family role.

Wellbeing

0   Severe Constant - High and constant levels of distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Unable to express or control emotions appropriately.

1   Frequently severe - Moderate levels of distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Becomes concerned easily, requires constant re-assurance/support, needs clear/tight limits and structure, loses emotional control easily.

2   Moderate consistent - Distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy in unfamiliar situations, frequent emotional encouragement and support required.

3   Moderate Frequent - Distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Controls emotions with assistance, emotionally dependent on some occasions, vulnerable to change in routine, spontaneously uses methods to assist emotional control.

4   Mild Occasional - distress / upset / concern / frustration / anger / embarrassment / withdrawal / severe depression or apathy. Able to control feelings in most situations, generally well adjusted/stable (most of the time/most situations), occasional emotional support/encouragement needed.

5   Not inappropriate - Well adjusted, stable and able to cope emotionally with most situations, good insight, accepts and understands own limitations.

*(taken from Enderby P, John A & Petherham B (2006) Therapy Outcome Measures for Rehabilitation Professionals. Second Ed., appendix 7, page 122-3)

The TOM as it appears in the client record pack

TOMs: Please enter a score from 0 – 5 for each category in the box to the right (you may use half points if necessary)

1 0	**Impairment**	
1 1	**Activity**	
1 2	**Participation**	
1 3	**Wellbeing**	

Enderby, P., John, A., Petherham, B. (2006) Therapy Outcome Measures for Rehabilitation Professional, Chicester, John Wiley and Sons.

Case study using TOMs

Mrs PR has had multiple sclerosis for 15 years. She is severely ataxic and has increased tone in all limbs. Her sitting balance is poor.	Impairment score = 2
Mrs PR uses an adapted wheelchair and all aids and appliances in the home effectively. She is in an adapted accommodation and can get to the local shops. She is able to care for the house, prepare meals and communicate effectively.	Activity / Disability score = 3.5
Mrs PR plays an active social role, she is a school governor as well as acting on the local community health council. She enjoys her garden and wheelchair dancing.	Handicap / Participation score = 4.5
Mrs PR is a determined, resourceful lady who, not surprisingly, becomes concerned and frustrated on some occasions, but is generally positive and uses good emotional support strategies.	Wellbeing / Distress score = 4
Mrs PR has a severe level of impairment but overcomes most functional restrictions using resourcefulness and appropriate aids. Thus, she is only partially limited in activity and is not socially disadvantaged in any specific way.	Summary

Taken from Enderby P, John A & Petherham B Therapy Outcome Measures for Rehabilitation Professionals. Second Ed. 2006 (Enderby et al., 2006) page 15, table 1-5.

Quality of Life

Increasingly the effectiveness of health and social care interventions are being measure according to whether they improve the quality of life of the client. The argument is that if treatments don't improve quality of life then they are ineffective. The EuroQoL questionnaire is perhaps the most used, health related quality of life measure in the world.

The EuroQoL or EQ-5D

The EQ-5D is a standardised instrument to measure health status or health-related quality of life. The EQ-5D is designed for self-completion by clients. It is simple, and takes only a few minutes to complete. Instructions for respondents are included in the questionnaire.

There is good evidence for reliability, validity and responsiveness for the EQ-5D and is recommended where a change in health is expected (Haywood et al., 2005). It has also been translated and validated in several different languages.

How do I use it?

The client should complete the EQ-5D themselves. Ask them to complete the two pages of the questionnaire both at admission / entry to service process and again on discharge / end of service provision.

If they are unable to complete the questions, please read out questions and choice of answers and fill in the responses they give. If the patient is unable or refuses to answer the questions please leave the EQ-5D blank and indicate the reason in the section below the questionnaire titled 'For completion by staff'.

Copies of the EQ-5D area also available in other languages, from the EuroQoL website.

Further information

Eq-5D website http://gs1.q4matics.com/EuroqolPublishWeb/

Haywood KL, Garratt AM, Fitzpatrick R. Quality of life in older people: a structured review of generic self-assessed health instruments. *Quality of Life Research* 2005;14: p1651-1668

Patient Satisfaction

Patient and Public Involvement in design and delivery of health and social care services has been a central area of development over the past 15 years in England and Wales. Measuring patient perspectives about how well you deliver your service is therefore very important. However, finding robust measures of patient satisfaction is difficult. The Patient Satisfaction Instrument we have included here has worked well in our studies.

The Patient Satisfaction Instrument

The patient satisfaction instrument was developed and validated in the context of the National Evaluation of Intermediate Care, conducted by the Leicester and Birmingham Universities (Barton et al., 2005). The researchers have successfully used these surveys in other evaluations of intermediate care.

What do I need to do?

Distribute the surveys to patients and carers at the end of their episode of care with your service and ask them to complete it as soon as possible. It is helpful to give the survey with a pre-paid envelope addressed to those who will input the data. It is important to stress that they will not be identifiable in any way. As detailed on their information sheet, clients are not obliged to complete the survey.

A complete client dataset contains:

1. General Demographic Data
2. Client admission and discharge
    a. TOM
    b. EQ-5D
    c. 8 Levels of Care scores
3. A complete record of staff contact for that client

The client record back is available in the appendices of the full project report of the NIHR SDO project "Enhancing the Effectiveness of Interprofessional Team working: Costs and Outcomes (NETSCC SDO08/1819/214).

Collecting Data on your Service – The Workforce Dynamics Questionnaire

It is increasingly rare in modern health and social care services for individuals, or individual disciplines to deliver care in isolation. Increasingly care is delivered by interdisciplinary teams made up of a range of staff from different professions and disciplines collaborating together. Being able to effectively measure the climate within interdisciplinary teams and how well they are working together is very important, though not often considered.

About The Workforce Dynamics Questionnaire

The Workforce Dynamics Questionnaire allows the collection of data about 8 factors that are related to healthy team functioning.

The WDQ was developed as a result of research to explore the impact of increasing workforce flexibility on Community Rehabilitation and Intermediate Care Teams serving older people (Nancarrow et al., 2005, Nancarrow et al., 2009a). It attempts to quantify the degree of role flexibility within teams; identify factors affecting the degree of workforce flexibility; and, assess the impact of workforce flexibility on a range of intermediate staff outcomes. The WDQ also collects descriptive data on factors such as age, salary grade, length of service and contractual arrangements (e.g. full-time, part-time, and temporary).

What do I need to do?

Distribute the surveys to individual staff members within your team or service. It is important to stress confidentiality by ensuring that staff will not be identifiable in any way. As detailed on the information sheet, they should not be obliged to complete the survey. If you are planning some sort to use the IMT intervention or planning some sort of change to your service, it is advisable to ask staff to complete the WDQ before and after the intervention or change, as this will allow you to identify changes. Research in the NIHR SDO project "Enhancing the Effectiveness of Interprofessional Team working: Costs and Outcomes (NETSCC SDO08/1819/214) has shown that there are significant relationships between some staff and team variables measured by the WDQ and patient outcomes.

Table 4-0-1 – Domains of the Workforce Dynamics Questionnaire

	Domains (Cronbach α)	No of items	Description
1.	Overall satisfaction	1	Overall level of satisfaction with the job.
2.	Autonomy (0.807)	4	The extent to which a practitioner has control over his / her own work or that of others.
3.	Role perception (0.749)	9	The way a practitioner perceives his/her role is understood and valued by other people (practitioners and the public).
4.	Role flexibility (0.738)	6	The extent to which a practitioner perceives can alter his /her role to meet the needs of the Team or service users.
5.	Integration with peers and colleagues (0.711)	3	The level of support available to the practitioner from a member of his / her own professional group.
6.	Team working (0.876)	10	The level of coherence and harmony within the team.
7.	Management structures and styles (0.900)	5	The overall extent of satisfaction with the management of the team.
8.	Access to technology and equipment (0.735)	4	Ability of the staff member to access necessary administrative support and equipment to do their job.
9.	Training and career progression opportunities (0.808)	8	Support for and satisfaction with the career development opportunities offered by the current post.
10.	Quality of care (0.768)	2	Staff perception of the quality of patient care provided by their team.
11.	Uncertainty (0.682)	4	Measures staff uncertainty about the future of their team and their role within the team.

Help with developing performance measurement

Copies of the measures outline in this section are contained in the appendices of the project report for the EEICC project (Enhancing the Effectiveness if Interprofessional Team working: Costs and Outcomes). This project was funded by the National Institute for Health Research Service Delivery and Organisation programme (project number 08/1819/214).

For information and advice regarding setting up robust performance measurement systems and/or using any of these tools please contact the EEICC team. (See details below)

Contact information

Should you have any concerns, queries or if you want to discuss any aspect of the project please contact Susan, Steven, Tony or Pam at any time.

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Tony Smith   t.smith@shu.ac.uk

Steven Ariss   s.ariss@sheffield.ac.uk

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