Designing teams that work

WENDY WAKE-DYSTER

Wendy Wake-Dyster is Director of Therapy Services, Crippled Children's Association of South Australia.

Abstract

This paper describes the development of clinical improvement teams in a multi-disciplinary acute health care setting. The process included an information-gathering phase that enabled a match of team structure and leadership to staff skills and experience. It was found that an environment that supported collaborative practice and shared decision-making was critical to staff support of the teams and the outcomes achieved

Background

During 1995 and 1996, the Allied Health (AH) departments at the Women's and Children's Hospital (WCH) undertook an internal review to create an AH Vision and Values statement and a new AH Divisional structure (Astley 2000). The structure comprised three multi-disciplinary Programs based on the patient care areas of Paediatrics, Pharmacy and Women's Health. Building works enabled the physical relocation of the previous profession-based departments to the Program areas. The Paediatric Program included five professions and paramedical and administrative support staff totalling 60 staff.

With the organisational and physical environment changes, and the size of the Paediatric Program, it was apparent to the AH management team that new communication, decision-making and leadership systems were needed. After three years work focused on structural issues, the AH management team determined that any further change should aim to reinforce the multi-disciplinary service delivery model to achieve patient care improvements.

Health care staff are socialised into profession roles, with learning about interdisciplinary practice occurring on the job and dependent on the leadership and environment (Lewis et al 1998). The predominance of discipline-specific reward, supervision and education systems leads to difficulties with collaboration across professions. Team members should focus on patient needs to overcome professional boundaries with a clear team purpose based on diagnostic or patient groups (Mickan and Rodger 2000).

To be effective, teams need to develop norms that reinforce behaviours building trust, group identity and group efficacy (Druskat and Wolff 2001, Lewis et al 1998, Mickan and Rodger 2000). Team maturity and motivation will increase through mission clarity, organisation and cohesiveness (Janz et al 1997). It is recommended that teams set their own goals and that appropriate information, feedback, education and training processes are established (Kirkman and Rosen 1999). Early team success reinforces efficacy, as does social modelling from more mature teams (May and Schwoerer 1994). Processes to achieve team communication, decision-making and conflict management are required. In the longer term, team maintenance processes should be established including managing external relationships and appropriate information exchange and feedback between the team and manager (Renneker 1996). Armstrong and Roten (1986) described a team development hierarchy, where team goals and roles should precede any work on developing team processes. Poor interpersonal relationships within teams can be indicators that preceding issues in the hierarchy have not been addressed.

Highly empowered teams are most effective, particularly in working with complex tasks (Kirkman and Rosen 1999). Kirkman and Rosen (1999) consider team autonomy to be the most important of the four dimensions supporting empowerment, with potency (the belief that a team will be effective), meaningful task and

organisational impact also contributing to empowerment. The team should be designed to deliver integrated services, with team member interdependency encouraging co-operation (Janz et al 1997, Kirkman and Rosen 1999). Appropriate skills and resources are required, with an explicit leadership style that is related to the team development stage (Mickan and Rodger 2000).

There is limited literature regarding health care teams, with effective teamwork often assumed without consideration of the organisational context, culture and type of team required (Mickan and Rodger 2000). The importance of the design stage, planning and preparation of participants is often forgotten (Renneker 1996). In 1997 the North West Health Care Network in Melbourne commenced a process to develop self-managed teams in allied health (Compton 1998). Law (1999) reviewed a range of Allied Health organisational structures within Australia and internationally to identify critical success factors for the design of an Allied Health structure at Flinders Medical Centre. Although a number of acute health settings have now developed a program based structure, at the time the AH model at WCH was unique to acute care in Australia. The leadership team wanted to develop a WCH Allied Health team model recognising the journey staff had experienced, consistent with the shared decision making culture.

Designing the teams

Our objectives were to develop a team structure to improve patient related communication and co-ordination within Allied Health, with referrers and external Allied health providers; and to increase emphasis on response to consumer needs (including the ability to identify and implement improvements needed for quality patient care).

Semi-structured interviews were conducted with Allied Health staff who had worked in multi-disciplinary teams or had experience and knowledge of team development. Nine staff were interviewed across four professions and management (Figure 1).

Semi-structured interviews were conducted with staff external to AH who had been involved in large-scale team development or training. This included two nursing and administrative managers from the WCH and two Allied Health managers at other hospitals (Figure 2).

Figure 1: allied health staff interview

What has assisted teams you have worked in to perform effectively?
What have been the barriers in effective team performance and function?
What are the most important issues for developing small teams in the Paediatric Program?
What are the key skills and competencies for the role of team facilitator?
What may assist the team facilitators in their role?
What may be barriers in the facilitators being able to develop effective teams?

Figure 2: external staff interview

What process was used for planning and developing the teams?
How was leadership of the teams determined?
What degree of structure was there in the team development process?
What training and learning opportunities were there for leaders and teams?
How was diversity in team and staff skills and readiness managed?

Meetings with a range of Allied Health groups identified issues that were specific to the Paediatric Program. This highlighted the need to develop a "customised" team model incorporating issues from a broad group of five professions, with differing degrees of interaction and commitment. Some staff worked within one clinical area and others across two or more clinical areas. While most staff worked by way of direct patient intervention, there were some staff with a level of consultancy work within and external to AH.

Some staff had high levels of clinical interaction within AH, developing trans-disciplinary practices that reflected high levels of trust and inter-professional respect, whereas other staff worked more closely with staff external to the AH Division. Staff were clear that after three years concentrating on divisional structure, there was energy and commitment to focus on patient improvements, not on further structural changes.

A literature review was conducted focusing on factors in team effectiveness and team development. Critical success factors were developed from the interviews and literature that staff felt they could "own" and they were incorporated into the team structure, process and leadership.

A team needs a *clear purpose* for its existence that makes sense to all team members (Janz et al 1997). It was decided that team structure would be based on clinical interdependency - that is, staff who worked together with children and families were grouped together in teams. This maintained staff together who already had high degrees of interaction to model effective team behaviour. All occupational therapy, orthotics, physiotherapy and speech pathology staff clearly identified a team, but because social work caseloads were allocated by medical clinic, they did not all line up with an AH team.

Most effective teams range from *6 -10 members, with physical proximity* increasing team interaction and effectiveness (May and Schwoerer 1994). This size provided a range of experience and professions (where appropriate), with teams of approximately equal size and each located within one area.

A *clear model of leadership* is needed, which is consistent with the organisational context, task and team member's needs (Wolf et al 1994). Given the shared decision making within AH, and a range of leadership skills, it was decided that a facilitator would be identified for each team based on a match of team and facilitator skills.

A range of essential leadership skills was identified (Figure 3). These included that the team should *agree upon norms and behaviour*. The AH Division had already identified AH values and developed a decision making matrix. This process was revisited for the smaller teams. The teams and facilitators need to be accountable for achieving results and to receive the *support and resources* to enable this to occur. The facilitators reported to the Program Manager and a process for reporting to the AH management team and linking to the AH Business Plan was identified. A training and development process was proposed for the facilitators.

Figure 3: essential leadership skills

Ability to see the big picture
Understanding of professional skills within the team
Motivational skills including the ability to motivate through influence
High level of verbal and written communication skills
Objective
Open listening skills, non-judgmental
Ability to work with diversity and conflict
Creative thinking, proactive
Ability to modify facilitation style dependent on team skills
Able to seek and provide support, ideas and learning opportunities within team facilitators group
Knowledge of quality improvement approach to planning
Knowledge or willingness to learn regarding stages of team development
Understanding of team decision making and problem solving processes

A process to *guide teams through their development* with appropriate leadership, resources and training is needed (Lewis 1998). The model described by Armstrong and Roten (1986) was used. The different starting point and skills within the teams was acknowledged by *flexibility* in the team model and team development framework. It was acknowledged there would be different rates of progress for teams who had worked together closely, and those who were being brought together more reluctantly. Using situational leadership principles, as described by Hershey and Blanchard (1993), the skills and readiness of the team members and facilitators were considered. The current style of working (where groups had worked together) was assessed using the High Performance Team model (Wolf et al 1994).

The team model is based on differing degrees of interaction, represented by concentric circles with the child and family at the centre. The key workers are staff who are involved in the care of most of the children seen by the team having a high degree of interaction. The team consultants represented in the next circle are staff who provide direct care to some children seen by the team, or who provide consultancy services to the key workers. These staff are also valuable team members, but do not have a high degree of interaction " forced" on them if it does not make clinical sense. Teams comprised Babies, Pre-school, School Aged, Neurology-Rehabilitation, Orthopaedic and Respiratory teams.

The model was tested by checking "fit" of proposed membership. Based on members' experience of working together, each team was asked to consider if the team development process was appropriate and to consider the team starting point. The team was asked to describe their current issues and to consider which model of facilitation they needed, and any specific skills they needed of the facilitator.

Implementing the model

The exact membership was confirmed for each team, requiring some minor modification of the first proposal. Staff identified which "circle" they fitted, confirming the degree of interaction and strategies to participate in the team development processes. Because of the diversity of clinical services provided by Allied Health, some staff were members of more than one team. Staff were required to identify a "home" team, attending team meetings for one team, with input being sought in other ways as relevant.

Social Work staff identified a team based on clinical areas (such as Neurosurgery or Respiratory) or where they undertook a team consultant role based on their broad social work skills. While the model initially placed only AH Division staff within the teams, three teams identified the need to invite other staff from nursing, psychology and health promotion to be part of their team.

The Program Manager assessed the skills, motivation and readiness to work in teams. Using the Situational Leadership matrix, a match of leadership style and team status was developed (Hershey and Blanchard 1993). In addition, the teams were asked what they felt they needed in the way of team facilitation. The current issues described by the teams were considered in the skills needed of the facilitator.

There were benefits and limitations associated with both facilitators who were team members and those who were external to the team. An external facilitator could be more objective but may not have knowledge of the clinical and team issues. A team member /facilitator may find it difficult to undertake dual roles.

There was some debate about the selection process for team facilitators. Because of the customised nature of the team model, it was felt that specific facilitators were needed for particular teams. Facilitators were identified and allocated to the teams by the Program Manager using staff in formal leadership positions and those with the personal attributes to take on leadership roles.

The facilitators reported back on progress by way of monthly group meetings with the Program Manager, at Program staff meetings and by way of Quality Improvement and Business Plan reporting processes within the AH Division. The formal meetings were an opportunity for facilitators to learn from each other, to identify what had worked and where they were experiencing difficulties. They provided a co-ordinating mechanism to ensure strategies implemented by one team did not adversely affect another team and that good ideas from one team could be applied across the Program. The Program Manager also took on the role of a team facilitator and was able to demonstrate some of the tools that were used to develop team vision and goals.

A range of team and facilitator training options were identified, considering the skills needed as the teams moved to a greater level of autonomy. The training needs were discussed with the facilitators and sessions conducted on team decision making tools and conflict management. The training model supported a high level of devolution to the teams of administration and human resource processes. This has not been taken up to date, with the teams focusing on patient care processes.

A consistent team development framework was used. Teams were asked to identify their team vision and goals for the next two years to improve patient care. Each team identified issues related to team member roles and processes that were needed for the team to function effectively. Some teams spent considerable time to create a team vision and identified team norms and values. Other teams proceeded through this phase more quickly and focused on clinical improvement goals. Review of the process has expanded the small team role beyond clinical improvements to include a communication function for Program administration issues.

Results

The team facilitators were asked to identify where they believed the team fitted along the team development continuum (Wolf et al 1994). After 12 months most teams reported they were working as a proactive team, having progressed from reactive or responsive stages. As facilitators settled into their roles, they noted the need to use a less directive and more facilitatory style in working with their team. The facilitators group also provided support for the Administrative Services Co-ordinator during a change process within administrative staff.

Each team identified a "Team Vision" and developed clinical improvement goals. In most teams, roles were clarified within and across professions. The Babies and Orthopaedic teams, which brought expanded groups of staff together, identified each team member's role related to various client groups and developed clinical protocols and screening checklists. This resulted in more streamlined co-ordination of patient care.

Processes were identified for each team including meetings, social events, team communication and case discussions. The Pre-school team scheduled a quarterly review meeting for client programming across professions. A multi-disciplinary database was set up for waiting list management and prioritisation across professions, initially in the Pre-school and Neurology-Rehabilitation teams. The Neurology-Rehabilitation team set up multi-disciplinary outcome measures in conjunction with medical and nursing staff. A team orientation package was developed for rostered and new staff in the Respiratory team. The School aged team planned a multi-disciplinary workshop for teachers. Improved professional relationships were commented upon in a number of teams. Improved links were established with areas external to AH as teams initiated discussions with other hospital or community staff.

The Neurology-Rehabilitation team had previous experience working as a team with staff with a high degree of motivation and teamwork skills. Most of the issues identified by this team related to interfaces with other WCH departments and external agencies. The team requested an external facilitator and was allocated a staff member in a formal leadership role. The team comprised all professions within the Paediatric Program with strong representation from social work, reflecting their key role in this area.

The team soon identified that their issues and team goals would be better addressed by inclusion of non AH Division team members. Nursing and psychology staff were represented at each meeting, with medical staff included on a regular basis. The team focused on identifying and implementing appropriate multidisciplinary outcome measures, developing client pathways and provision of client information. There was extensive liaison with external agencies to develop pathways that extended beyond the hospital admission and in providing accurate client information. When the initial facilitator was unable to continue in the role, the team decided to use a shared leadership model, with a key contact person identified for the facilitators meetings.

The Pre-school team included membership from all professions with social work identified in a consultant role. The main issues for this team were clarifying professional roles and priorities. The Pre-school team was allocated an internal facilitator, with an external facilitator identified for some issues where it was recognised that the regular facilitator needed to take on a participant role. The Pre-school team set up a three-year plan to move towards multi-disciplinary practice and increased community links.

The Orthopaedic team came with limited experience working in an AH multi disciplinary team and with strong profession-based identity. Issues related to internal interfaces, role clarity and identifying and committing to a multi-disciplinary focus. An internal facilitator was used who had existing profession based leadership responsibilities. This created difficulties in dealing with the dual roles, although there was strong willingness to undertake this challenge. The team spent less time on vision and goals than other teams and was more action oriented, recognising the need to gain team commitment from visible results.

Discussion

Weaknesses

The teams initially focused on clinical improvement goals. As the communication difficulties in a Program of 60 staff became apparent, the teams were also used for information sharing and administration issues. This supported the multi-disciplinary model and the divisional structure. A combined focus initially may have strengthened the role of the teams.

After extensive consumer and referrer input to the design of the AH Division structure, the small team process was internally focused. There was no mechanism to include consumer or referrer input. The teams comprised AH members only, with three teams subsequently seeking external members. More energy should have been directed to gaining political support within the organisation. It has been recognised that it is not sufficient to work internally but there is a significant need to build support and investment externally.

Training and resources to support the development process were limited by the Allied Health budget. Better understanding of the resources needed for training may have led to seeking funding outside the Division or external to the organisation. Clinical demands placed limitations on time for leadership development for facilitators and for staff to meet as a team. The monitoring and reporting method varied due to workloads of the facilitators and the Program Manager.

The initial development plan included an extensive training program to support the transfer of team administrative functions such as recruiting and appraisal. This training program was modified to respond to facilitators' and team needs and the stage of team development. While the clinical demands, staff skills and time frame limited achievement in some areas, the process did achieve autonomous multi-disciplinary clinical improvement teams.

Strengths

The team development process was consistent with previous work within the AH Division and with the culture and context of the organisation. Staff demonstrated a strong commitment for teamwork and patient care improvements. Investment in the initial information gathering stage and providing the opportunity for feedback was consistent with the divisional decision-making model and essential to maximise the chances of success.

One of the main strengths was the knowledge of staff skills by the Managers initiating the process. The use of the Program Manager to undertake this project brought an understanding of the diversity of the staff group and the degree of change staff had worked through over the previous three years. This enabled the model, processes and facilitation to build on staff's current situation rather than requiring a disruptive change process. The use of situational leadership principles led to an acceptance of " where staff are at" and a focus on moving them along the team development continuum

The use of team facilitators and informal and formal support structures built leadership capacity within the Program. This also benefited the organisation, with skills and experience of these staff available to the broader organisational teams. The support structures for facilitators assisted cross-team learning and aimed to prevent teams developing ideas in isolation.

Implications

The use of an approach such as this highlights the need to build commitment from staff. Unless staff are generally supportive of a multi-disciplinary team model, it will not succeed. Additional skills are needed by staff and facilitators to work in teams. These skills of active listening, flexibility, conflict management and consensus building must be nurtured. At times the teams and the facilitators experienced difficulties and needed encouragement and to experience success.

The level of information gathered to develop the model highlights the benefit of using an internal consultant or alternatively the need to set up an extensive information gathering process. Designing a "customised" team model is resource-intensive but AH management and staff considered investment in the early stages to be worthwhile.

The critical factors in team effectiveness identified in the literature and by interview were confirmed by our experience. We identified the need to place a greater emphasis on the context and relationship to the organisation. There is a clear need to manage external interfaces. Political support should have been engaged, including executive sponsorship, funding for higher duties and training and linking with organisational or external projects to maintain profile. Consideration should be given to team leadership and membership beyond AH when developing AH teams. Autonomous teams require a large investment in training and support and time to demonstrate results. It may not be possible to provide this in a reducing environment where short-term financial considerations conflict with longer-term quality improvements.

Conclusion

The team development process within Allied Health has achieved outcomes in improved team effectiveness and co-ordinated patient care by valuing and balancing individual profession and multi-disciplinary perspectives. This requires that we develop professionals who are skilled in their clinical areas and have the ability to work in diverse teams. By doing this we are developing individuals and teams who can embrace the changes and challenges in health care.

References

Armstrong H & Roten A 1986, *'Developing Effective Health Teams'*, Continuing Education Support Unit, University of New South Wales.

Astley J 2000, 'Transforming Allied Health', *Australian Health Review*, vol 23 no 4, pp 160-9.

Compton J 1998, *'A Team Approach to Organisational Restructuring: North Western Health Experience'*, 3rd National Allied Health Conference, Brisbane.

Drusket VU and Wolff SB 2001, 'Building the emotional intelligence of groups', *Harvard Business Review* 79(3) 80-90.

Hershey P and Blanchard K 1993, *'Management and Organisational Behaviour,'* Prentice Hall New Jersey.

Janz BD, Colquitt JA & Noe RA 1997, '*Knowledge worker team effectiveness: the role of autonomy, interdependence, team development and contextual support variables*', Personnel Psychology 50(4) 877-904.

Kirkman BJ & Rosen B 1999, *'Beyond Self-Management: Antecedents and consequences of team empowerment'*, Academy of Management Journal 42(1) 58-74.

Law D (1999), *'Allied Health Organisation- A study of Australian and overseas models'.*

Lewis RE, Tudor R, Tsao H, Canaan E 1998, 'Improving interdisciplinary team process: a practical approach to team development', *Journal of Allied Health* 27(2) 89-95.

May DR & Schwoerer 1994, 'Developing Effective Work Teams: Guidelines for Fostering Work Team Efficacy,' *Organisation Development Journal*, 12 (3) 29-39.

Mickan S & Rodger S 2000, 'The organisational content for teamwork', *Australian Health Review*, 23(1) 179-192.

Mickan S & Rodger S 2000, 'Characteristics of Effective Teams', *Australian Health Review*, 23 (3) 201-8.

Renneker JA 1996, 'Team Building for Continuous Quality Improvement', Seminars in Perioperative Nursing, 5(1) 40-6.

Wolf G, Boland S and Auckerman M 1994, 'A transformational model for the practice of professional nursing,' *Journal of Nursing Administration* 24 (4) 51.