The Clinical Teams Project

Evaluation report

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October 2006

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Acknowledgements

We would like to thank the following people who supported and participated in the project:

✦ the team representatives, the teams, those who use their services, and the programme sponsors, for taking part in this project

✦ the NHS Leadership Centre for commissioning the project, and specifically John Lancaster and Christina Pond for their lead and support from the Centre

✦ Lynn Markiewicz, Caroline Lush and Jeremy Dawson from Aston OD Ltd for providing training and ongoing support in the use of the TPI, supporting the administration of the TPI, entering and analysing TPI data and producing the TPI team reports

✦ All the members of the Advisory Group for their guidance, critique and support.
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Executive summary

Background

The best and most cost effective outcomes for patients and clients are achieved when professionals work together, learn together, engage in the clinical audit of outcomes together and generate innovation to ensure progress in practice and service (DH, 1993).

Research shows that effective team working can make a substantial contribution to reduced hospitalisation time and cost, increased patient safety, improved patient health and innovations in patient care as well as enhanced staff motivation and well-being (Borrill and West, 2002).

In the 2004 NHS Staff survey (Healthcare Commission, 2005) 91 per cent of staff said they worked in a team; however when the survey probed more deeply and asked questions about the structure and processes of their teams, only 43 per cent were working in teams that met the evidence-based criteria for well-structured and effective teams.

To support health and social care team working and increase the number of effective teams, the NHS Leadership Centre commissioned the RCN Institute (RCNI) to design, deliver and evaluate a team development programme – the Clinical Teams Programme (CTP) – for 100 health and social care teams across England between January 2004 and September 2005.

In total, 101 teams from 55 organisations completed the 10 month CTP. Each participating team nominated two or three people to act as team representatives and lead the programme for their team. The teams and their organisations were supported through the programme by an experienced facilitator from the RCN.

Qualitative evaluative data about the structure, process and outcome of the CTP were gathered from team representatives, the organisational managers who sponsored the programme, and programme facilitators. Quantitative data about the extent to which teams increased their effectiveness was collected using the Team Performance Inventory (TPI) (West et al., 2004).

Findings

Evidence from these data showed that the programme was successful in supporting teams that took part to:

✦ increase their effectiveness and team functioning
✦ make improvements to client care and service delivery
✦ contribute to the strategic objectives of their organisations.

Key factors in the teams achieving positive outcomes were:

✦ team size
✦ the extent to which team representatives could access authority and power from their seniors, their colleagues and from within themselves, to successfully engage others and influence change
✦ the presence and expertise of a facilitator.

Positive changes took place for the team representatives, their teams and in the services they provided for clients.

For team representatives, the changes included:

✦ a transformed approach to change
✦ improved leadership capabilities
✦ an ability to see the ‘bigger picture’
✦ the acquisition of new knowledge and skills
✦ an improved ability to work with others
✦ the enhanced sense of an individual’s power and ability to influence change.

For their teams, the changes included:

✦ more proactive and action-oriented
✦ an improved relationship between teams and agencies
✦ an increased awareness of the ‘bigger picture’
✦ increased leadership
✦ increased morale and motivation
✦ increased clarity of individual roles and the contributions of self and others
✦ increased effectiveness in working with conflict
✦ more open dialogue and critical reflection
the increased involvement of all team members
changes to team processes and structures.

For clients and services, the following developments were identified:
- greater client-centred service provision
- improvements to the client pathway
- improvements to the environment of care
- improved meal times
- greater integration within teams and across services
- improvements in the way teams organise service delivery
- increased access to a range of services.

The following local and national policy initiatives were supported through participation in the CTP:
- Patient and Public Involvement
- National service frameworks, particularly older people and long term conditions
- Valuing People
- Clinical Governance
- The Essence of Care
- Improving Working Lives
- Standards for Better Health
- integration of health and social care
- admission avoidance
- shared governance.

Interventions supporting team development

The CTP should be seen as a whole programme, however the evaluation identified that different elements were particularly useful in supporting different aspects of change:
- for personal development, the opportunity to work with people from different teams, different disciplines, different organisations and different levels within the hierarchy within a learning culture that fostered critical thinking, reflection and support, was seen as invaluable. The process of action learning brought these elements together and, as an approach, was highly valued
- in relation to achieving change within teams, the increased knowledge gained about how teams work and the introduction of tools and techniques for translating the theory of effective team working into practice helped the team representatives get the rest of their team involved in team development
- team events, facilitated by an experienced ‘neutral’ facilitator, together with an action-oriented approach was important, as was paying attention to team dynamics and processes
- using patient stories and observations within an action-oriented approach and creating the space to reflect, think and plan, helped implement improvements in client care and service delivery.

The main challenges to participating in the programme were:
- the investment required, in terms of releasing staff from clinical work
- working within the team dynamics that either pre-existed the programme, or were raised in response to exploring collaborative working and implementing change
- securing sufficient support from managers and team colleagues.

The changes achieved through participation in the CTP indicate that the teams developed some of the necessary capabilities required to work effectively with current service provision challenges including:
- the provision of integrated care pathways
- getting the most from available expertise
- patient safety
- innovation, spread and sustainability
- the complexity of working across service and organisational boundaries.
Conclusions and recommendations

✦ Creating time and space for people in the same team, from different disciplines and different levels of the hierarchy, to talk to each other and think about what they do, how they do it and how they could do it better is essential in enhancing team effectiveness and improving services.

✦ An action-oriented approach that necessitates working together on real tasks is central to developing effective teams.

✦ Where team membership is reported as sizeable (over 15), time should be spent considering different ways to configure or conceptualise the teams so as to enable them to apply the principles of good team working to their systems and processes.

✦ Individuals and teams involved in implementing change need access to the necessary power and authority within themselves, their colleagues and their seniors in order to bring about change. Personal development, active support from managers and the provision of external support systems are required to enable individuals to effectively access this necessary power and authority.

✦ Facilitators that are experienced and skilled in working with group processes, and are perceived as neutral, are necessary for the exploration of inter- and intra-team dynamics.

✦ Programmes such as the CTP which involve implementing change and exploring team dynamics are neither straightforward nor easy. Those commissioning, participating in and facilitating such programmes should be aware of and anticipate this and provide the necessary support mechanisms to help people through the challenges.

✦ Time is required to allow some of the complex processes involved in change and collaborative working to be thought about, experienced, challenged, owned and implemented. Ten months was perceived as a good length of time to enable some of this to happen.

1. Introduction

1.1 Context

The need for effective team working to deliver high-quality care focused on the needs of service users and their carers runs throughout the NHS policy agenda (DH 2006, 2005a, 2004, 2003, 2001, 2000).

In the 2004 NHS Staff survey (Healthcare Commission, 2005) 91 per cent of staff stated they worked in a team; however when the survey probed more deeply and asked questions about the structure and processes of their teams, only 43 per cent were working in teams that met the evidence-based criteria for well-structured and effective teams.

To support the health and social care policy agenda and increase the number of people working in effective teams, the NHS Leadership Centre commissioned the RCNI to develop, deliver and evaluate a team development programme – the Clinical Teams Programme – for 100 health and social care teams across England, between January 2004 and September 2005.

This is the evaluation report of the project.

1.2 The Clinical Teams Programme

The Clinical Teams Programme (CTP) is a 10-month programme for multidisciplinary teams working in health and social care. The whole team participates, nominating two or three individuals to take on a lead role. These individuals are referred to as team representatives throughout this report.

The programme follows the principles of adult learning (Knowles, 2005) and incorporates experiential learning (Burnard, 2002), action learning (Revans, 1998) and the specific interventions of patient stories, observations and the use of the TPI. The different elements of the programme are described fully in section 1.5.
The aims of the programme are to:

✦ increase team effectiveness and team functioning
✦ improve client care and service delivery
✦ contribute to organisations meeting their strategic objectives.

1.3 Evidence base for the CTP

The CTP was designed and delivered by the project team at the RCNI. The programme drew on evidence from the RCN Clinical Leadership Programme (CLP) (Large et al., 2005; Cunningham and Kitson, 2000 a/b) and from research into team effectiveness undertaken by Borrill and West (2002).

Evaluation of the CLP demonstrated that key to its success is the ability to combine reality with vision through focusing on:

✦ the service user
✦ the local context of service delivery
✦ the broader strategic and political context
✦ the personal and professional development of individuals.

These elements were incorporated into the design of the CTP.

The work of Borrill and West (2002) highlights that effective teams are those that:

✦ have clarity of and commitment to team objectives
✦ fully involve all team members in the processes and activities of the team
✦ focus on quality through regular review and feedback on their performance in relation both to their team processes and achievement of their objectives
✦ support creativity and innovation.

The CTP was designed to enable participating teams to enhance or develop these aspects of team working, in order to increase their effectiveness.

In addition to the research mentioned above, the design of the CTP in terms of content, process and structure was informed by literature and experience in the following areas:

✦ effective team working
✦ leadership development
✦ service improvement
✦ change management
✦ organisational development
✦ quality improvement
✦ complexity theory
✦ group dynamics
✦ experiential learning
✦ adult learning
✦ action learning.

The five simple rules of the Modernisation Agency (MA) (see Figure 1) also provided a guiding framework for the CTP.

Figure 1 — Five simple rules

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>See things through the patient’s eyes</td>
</tr>
<tr>
<td>2</td>
<td>Find a better way of doing things</td>
</tr>
<tr>
<td>3</td>
<td>Look at the whole picture</td>
</tr>
<tr>
<td>4</td>
<td>Give frontline staff the time and tools to tackle the problem</td>
</tr>
<tr>
<td>5</td>
<td>Take small steps as well as big leaps.</td>
</tr>
</tbody>
</table>

Using a variety of processes, tools and techniques, the CTP provided a structure in which teams could examine the ways they were working, identify what was going well and not so well, and together make plans to improve the service they were providing for service users. The programme consists of several integrated elements, with each element influencing and supporting the others.

1.4 Key roles

The RCN project team

The design, delivery and evaluation of the CTP within the 100 teams, together with the leadership, management and co-ordination of the national project, were undertaken by the RCN project team. This team

¹ See Appendix 1 for the governance and management arrangements for the project
comprised a project lead, programme facilitators and a project administrator.

1.4.1 Project lead

Responsible for leading and managing the project team and the whole national project, the project lead played a key role in the overall design of the programme structure and content. In addition, the project lead was responsible for designing the evaluation framework, coordinating the collection of evaluation data, analysing the data and writing the evaluation report. As well as the ongoing leadership and management of the facilitator team, the project lead was the primary contact for the NHS Leadership Centre and also acted as the national contact and support for CTP in the teams and organisations that took part.

1.4.2 Programme facilitator

Fourteen programme facilitators were employed to design, facilitate and evaluate the CTP. In addition, the programme facilitators were responsible for:

✦ establishing relationships with all stakeholders in the organisations taking part
✦ working to enable maximum support for the programme within each organisation
✦ ensuring the objectives of the programme were in keeping with the overall objectives of the organisation
✦ enabling communication about the process, impact and outcomes of the programme
✦ facilitating the different elements of the programme.

The facilitators came from a range of professional backgrounds, including nursing, social work, occupational therapy, medicine, psychotherapy and organisational consultancy. As well as expertise in facilitation, team members brought extensive experience of working in a wide range of health and social care settings in different roles and with a variety of staff and service users, as well as their own histories, personalities and interests.

1.4.3 Project administrator

One full time project administrator was appointed to provide administrative support to the project lead and the programme facilitators.

1.4.4 Team representative

Each team that took part in the CTP was asked to nominate two or three individuals to perform as team representatives. In the context of CTP, the role of team representative was crucial, attending all elements of the programme (see section 1.5) and taking the lead for the programme in their teams.

The selection both of the teams and the team representatives was undertaken internally by the relevant organisations and their elected teams. The programme facilitators supported this process by providing information about the nature and purpose of the programme and the role of team representatives.

1.4.5 Programme sponsor

Primarily at director or assistant director level, programme sponsors were those individuals who had made the original submission requesting their organisation take part in the CTP. Programme sponsors acted as a first point of contact for the programme facilitators and had management responsibility for supporting and overseeing the progress of the programme in their organisation.

1.5 CTP content and structure

A representation of the programme and its constituent elements, together with a time line for the programme, are illustrated in Figures 2 and 3.
A brief description of each CTP element is given below.

**Establishing the programme within the organisation**

The focus for implementation of the CTP was the team and the team representatives; however the programme was underpinned by an understanding of the team within the system. Increasingly, current thinking regarding change processes within health and social care is being influenced by the complexity theory which views health and social care organisations as complex adaptive systems and emphasises the need to take a whole systems approach to change management (Plsek and Greenhalgh, 2001).

In relation to the CTP, the purpose of taking this approach was to:

- facilitate organisational support for the teams and individuals participating in the programme
- enable links to be made between the objectives of the teams and those of the organisation
- enable the work of the programme to be seen in the wider context of other relevant development initiatives within the organisation
- enable communication about the process, impact and outcomes of the programme in order to facilitate the spread and sustainability of good practice.

At the outset of the programme the facilitator established a steering group of stakeholders in each organisation. In some organisations a separate group was not established; instead the role was taken by an existing group. The purpose of the steering group was to support the programme within the organisation as described above.

The model which framed the thinking around the structure and process of the CTP is illustrated in Figure 4. The objective was to make explicit the inter-relationship between the organisation, the team and the individual (in this case the team representative) and the influence that these inter-relationships have on service provision.
Workshops

A total of nine one-day workshops were delivered within the first four months of the programme and an outline of the individual workshops are detailed in Figure 5. Run by the programme facilitator, the workshops were attended by the team representatives. The purpose of the workshops was to:

- establish a working culture within the group and create a climate that would foster exploration, dialogue, reflection, critique and action
- present the research evidence for what makes effective teams
- provide a variety of interventions, tools and techniques to help the team representatives translate theory into practice within their own teams.

Figure 5 – The workshops

<table>
<thead>
<tr>
<th>Workshop 1</th>
<th>Workshop 2</th>
<th>Workshop 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and overview</td>
<td>Developing individual leadership capabilities and the role of the team representative</td>
<td>What is a team?</td>
</tr>
<tr>
<td>✦ values</td>
<td>✦ personal development plans</td>
<td>✦ mapping the team</td>
</tr>
<tr>
<td>✦ philosophy</td>
<td>✦ the role of the team representative</td>
<td>✦ teams and networks</td>
</tr>
<tr>
<td>✦ frameworks</td>
<td>✦ setting team objectives</td>
<td>✦ what makes an effective team?</td>
</tr>
<tr>
<td>✦ evidence base</td>
<td>✦ achieving change</td>
<td></td>
</tr>
<tr>
<td>✦ establishing a working culture.</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workshop 4</th>
<th>Workshop 5</th>
<th>Workshop 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>Patient stories</td>
<td>Maximising participation – working with diversity</td>
</tr>
<tr>
<td>✦ how to do them</td>
<td>✦ how to do them</td>
<td>✦ power and authority</td>
</tr>
<tr>
<td>✦ handling feedback within the team.</td>
<td>✦ developing SMART action plans.</td>
<td>✦ including everyone.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workshop 7</th>
<th>Workshop 8</th>
<th>Workshop 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role clarification and working with conflict</td>
<td>Communication and team meetings</td>
<td>Focusing on quality</td>
</tr>
<tr>
<td>✦ responsibility</td>
<td>✦ using meetings effectively</td>
<td>✦ monitoring</td>
</tr>
<tr>
<td>✦ authority</td>
<td>✦ knowledge management</td>
<td>✦ measurement</td>
</tr>
<tr>
<td>✦ accountability</td>
<td>✦ recording and monitoring</td>
<td>✦ accessing and using evidence</td>
</tr>
<tr>
<td>✦ boundaries</td>
<td>✦ internal and external systems</td>
<td>✦ recognition and reward.</td>
</tr>
<tr>
<td>✦ working with conflict.</td>
<td></td>
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</tr>
</tbody>
</table>

Action learning sets

Action learning is a practical, reality-led, action-oriented approach to learning that has received wide credence among those working at all levels of the health and social care services (Marquardt, 2004).

Between four and eight team representatives formed a learning set that met monthly, commencing in the second month of the CTP and continued until the end of the programme – nine learning sets in total. The sets were facilitated by the programme facilitators, with each set lasting between three and five hours. The objective of the learning sets was to provide a supportive and challenging forum in which the representatives could discuss how the programme was progressing within their team and to develop strategies to support ideas being taken forward.
Team events

The team event element of the programme offered the opportunity for the whole team or a ‘critical mass’ of the team to work together. Over the duration of the programme, each team participated in a total of three one-day team events. The aims, content and structure of the events were negotiated on a local basis between the programme facilitator and stakeholders from the teams and organisations.

CTP interventions

The CTP included three specific interventions:

✦ the Team Performance Inventory (TPI)
✦ patient stories
✦ observations.

The TPI

The TPI is a validated assessment tool (West et al., 2004) developed originally for the Health care teams effectiveness project research (Borrill and West, 2002) and subsequently augmented and validated through use in a number of primary and secondary healthcare teams. The inventory takes the form of a questionnaire which is completed by all team members. Teams taking part in the CTP were invited to complete the TPI on two occasions; once at the beginning and once at the end of the programme. The TPI was used in two ways within the programme. Firstly as a development tool to provide teams with data concerning their stronger and weaker areas of team functioning and thus provide a focus for team development. Secondly, the first and second administrations could be compared to provide an indicator of any changes taking place in team functioning.

Patient stories

This is a technique developed and refined through the RCN CLP. It involves a team representative talking to a service user or carer about their experience of the service. The conversations are tape-recorded and are led by the service user or carer; in other words there is no predetermined interview schedule or questionnaire. Recordings from several interviews are analysed and emerging themes are used as a basis for action planning around service improvements.

Observations

This technique was also developed and refined through the RCN CLP. It involves two team representatives (one a member of the team being observed and the other a non-member) spending a period of time as observers in the service area. The focus for the observation was determined by the objectives set by the team for the CTP. The observers take notes during the observations and then feed back their observations to the team. Action plans are developed on the basis of these observations and the subsequent discussion following the feedback.

The strengths and limitations of the programme are discussed in Chapters 5 and 6, and Section 9.2.

1.6 Getting the project off the ground

The RCN project team was a virtual team consisting of a project lead, 14 programme facilitators and one administrator in various locations across England. The team held monthly team meetings in London. The 14 programme facilitators formed two action learning sets which also met monthly and were facilitated by the project lead.

The facilitators all started in post in January 2004. This provided a three-month period before the actual delivery of the programme began in April 2004. Throughout the project, the project team was conscious of the fact that it was a team whose purpose was to enable other teams to work effectively together. There were high expectations externally and also internally within the team that it should be a well-functioning team.

During these first three months time was spent establishing the project team, clarifying its purpose and objectives and setting systems, processes and ways of working in place that would help the team work cohesively together. The project team continued to work reflexively throughout the project through regular reviews of its own process, not only to assess how well the team worked but to see what could be learnt from its own experience that would help support working with
the teams participating in the programme.

During these first three months, the project team also:
✦ developed the detailed content of, and materials for, the workshops
✦ finalised the recruitment of organisations and offered support in the selection of teams and team representatives
✦ identified how the organisations would be grouped together and who would be working where
✦ started to establish relationships with key stakeholders in the organisations.

To meet the commissioned target of 100 teams, the programme was delivered in two cohorts, each containing 50 teams; one cohort started in spring 2004 and the other in autumn 2004.

Organisations were grouped together on the basis of the number of teams they were supporting, their geographical locations and the geographical location of the facilitators.

A programme facilitator from the RCN project team worked with each organisation taking part in the programme.

The team and organisation groupings were arranged so that each facilitator ran one programme of between three and nine teams in the spring cohort and one in the autumn cohort (see Appendix 2 for a list of organisations that took part).

1.7 Recruitment to the CTP

The CTP was targeted in the first instance to zero star organisations and organisations participating in other MA initiatives at that time (Pursuing Perfection, Improvement Partnerships for Hospitals, and Partnerships for Improving Primary Care).

The Leadership Centre initiated the recruitment of organisations. Information sheets and application forms were sent to cluster leads working in the Performance Development Team of the MA as well as the leads for the other MA initiatives. These leads then disseminated the information to organisations within their area. Interested organisations were asked to submit completed application forms to the project team at the RCN by the end of January 2004.

On the application form, organisations were asked to identify how participation in the CTP would contribute to the strategic objectives of the organisation. In addition they were asked to locate the management and steer of the programme within the existing organisational structure and to identify programme sponsors at every level within the organisation, from team leader to executive board. The application forms were signed-off by the participating organisation's chief executive. The RCN and Leadership Centre project leads reviewed all applications and places on the CTP were offered to organisations that could satisfactorily address the issues mentioned above.

Organisations were invited to submit either intra-agency applications, where all teams work within the same organisation, or inter-agency applications, where teams work for different partner organisations.
2. Approach to evaluation

Part of the remit for the CTP was to provide an evaluation of the programme. This was to be undertaken by the project team, as no external evaluation was commissioned.

Realistic evaluation (Pawson and Tilley, 1997) provided the broad theoretical underpinning for the evaluation framework of the project. This approach to evaluation addresses the question 'what works for whom and in what circumstances' and is seen as being particularly suited to evaluations of complex interventions, where issues of context and process as well as outcome are of significance (Redfern et al., 2003). Realistic evaluation examines the relationships between context, mechanism and outcome. In this instance 'mechanism' refers to the CTP; the programme as a whole and the different elements within the programme.

For ease of readability, rather than using the Realistic evaluation term 'mechanism', the more commonly used terms 'structure and process' will be used throughout this report.

In order to evaluate the CTP, data relating to the context in which the programme was delivered, the actual programme itself and the impact and outcomes of the programme were gathered, collated and analysed.

Data for the evaluation were collected from a variety of sources:

- organisations’ application forms
- registration forms completed by team representatives and teams at programme commencement
- workshop evaluations
- team event evaluations
- facilitator evaluations
- team representative evaluations
- telephone interviews with the management sponsors of the programme
- achievement logs, action plans and impact sheets
- pre- and post-administration of the TPI.

This report is intended as an evaluation of the CTP and not as a research study. Realistic evaluation provided a framework to guide our thinking and data collection rather than a methodology through which to undertake a piece of evaluative research.

Context

Data providing a broad contextual picture of the organisations, teams and individuals taking part is provided in Chapter 3.

Process, structure and outcome

The objective of this evaluation was to establish to what extent the CTP was successful in achieving its aims; whether taking part in the programme improved team effectiveness, were improvements to client care achieved, and finally, did it make any contribution to the strategic agenda of participating organisations? These data are reported in Chapters 4, 5 and 9.

Keeping in mind Pawson and Tilley’s (1997) question about ‘what works for whom and in what circumstances’, we also sought to identify the factors that influenced the achievement of any outcomes. Data relating to this aspect of the evaluation are found in Chapter 6.

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1 MREC approval for the evaluation was granted by Thames Valley Multi-centre Research Ethics Committee.
3. Context

To provide context to the programme, in this chapter we review who took part, where they came from and what their roles/responsibilities were. These data are drawn from the application forms that organisations completed prior to being offered a place on the programme, and from the registration forms that individual team representatives and teams completed once they had started the programme.

3.1 The teams

The programme was run in two cohorts – spring 2004 and autumn 2004. The spring cohort contained 50 teams; 45 teams completed the programme and five teams withdrew. The autumn cohort contained 57 teams, one of which withdrew.

Overall 107 teams took part, with 101 successfully completing the programme and six electing to withdraw following the workshop element which took place approximately four to five months into the programme.

The teams in both cohorts were grouped together, so that each facilitator could run one 10-month programme with a number of teams (between three and nine). In some instances the teams were from the same organisation and in others, teams from different organisations joined to work together for the duration of the programme. In some programmes the teams from different organisations shared a common care pathway, while in other programmes the different organisations had no service delivery connections.

Thirteen programmes ran in the spring cohort and 12 in the autumn cohort. In total 25 programmes took place, with each facilitator running one programme in each cohort.

The organisations

The 107 teams were from 55 different health and social care organisations and provided a variety of services for a wide range of service users. The different types of organisations taking part are illustrated in Figure 6, while the Strategic Health Authorities (SHA) within which the organisations were located are shown in Figure 7. The age range of the selected participants was from 25 to 52 years. The clinical grading of participants ranged from F grade (31%), G grade (50%), H grade (13%) and G/H grade (6%). The range of nursing experience varied between 3.5 years to 30 years (data from one participant missing).

Figure 6 – Participating organisation types

Figure 7 – Location of teams in SHAs

Characteristics of the teams

The teams were asked to identify the nature of the service they provided and these are illustrated in Figure 8.
Figure 8 – Service provision

- Mental health care: 9%
- Discharge services: 9%
- Learning disabilities: 9%
- Intermediate care services: 18%
- Social care services: 8%
- Not recorded: 2%
- Condition-specific: 23%
- Generic service: 22%

Figure 9 – Client or user age groups

- Between 18 and 65: 16%
- Over 65: 28%
- All ages: 41%
- Children and young people: 15%

Figure 10 – Location of service provided

- Clients own home: 23%
- Hospital unit: 22.5%
- Residential home: 13.5%
- Health centre: 9.5%
- Day centres: 7%
- Outpatients department: 8%
- A & E: 5%
- Theatres: 0.5%
- Social Services department: 2%
- Therapy departments: 3.5%
Team size

Of the participating teams, 26 per cent reported their team size was between 8 and 15 people – the number recommended in findings from the healthcare team effectiveness research (Borrill and West, 2002). There were differences in the reported team membership between cohorts and these are shown in Figure 11.

Figure 11 – Team size

<table>
<thead>
<tr>
<th>Number in team</th>
<th>Spring cohort (per cent)</th>
<th>Autumn cohort (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26+</td>
<td>46</td>
<td>23</td>
</tr>
<tr>
<td>16–25</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>8–15</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>1–7</td>
<td>2</td>
<td>22</td>
</tr>
</tbody>
</table>

The teams in the spring cohort reported higher team membership numbers than those in the autumn cohort. Two teams reported membership of 80 and 82 in the spring cohort, whereas 45 was the highest reported figure in the autumn cohort. Commentary on team size is picked up in the discussion section of this report (Chapter 9).

Not surprisingly, the majority of teams reported being in the midst of and/or anticipating major changes in a variety of areas, including service delivery, location, team membership, roles and management structures.

3.2 The team representatives

A total of 252 people across both cohorts registered on the programme as team representatives. These individuals came from a wide variety of health and social care backgrounds; 52 per cent were nurses and the remaining 48 per cent were from professions allied to health, social work, medical, managerial and non-professional backgrounds, for example support workers and clerical workers. These different disciplines are illustrated in Figure 12.

An assessment of job titles indicated that 55 per cent of the team representatives held positions that contained some role authority, for example matron, team leader, social services manager, consultant surgeon and clinical manager. The remaining 45 per cent however, held roles that generally did not assume position power, such as staff nurse, health care assistant, clerical assistant and housing support worker.

The team representatives were predominantly female (80 per cent) and of white British origin, with 10 per cent coming from black and minority ethnic communities.
4. Impact and outcomes

What difference did taking part in the CTP make?

This chapter identifies the impact of the CTP in relation to changes for the team representatives, the teams, and client care or service delivery. Initially, we present the results of the TPI, followed by changes reported by the team representatives, and finally those reported by the programme sponsors.

4.1 Results from the Team Performance Inventory (TPI)

The TPI is a validated assessment tool (West et al., 2004) developed originally for the Health care teams effectiveness project research (Borrill and West, 2002) and subsequently augmented and validated through use in a number of primary and secondary health care teams. The version of TPI used in this project is a self-report questionnaire that assesses team-working in 16 dimensions. The dimensions of the TPI are shown in Figure 13.

The TPI was chosen because of its robust reliability and validity and because of its development as a research tool within the healthcare sector. Ongoing studies, for example using the TPI to predict performance in multidisciplinary healthcare teams, confirm the validity of the tool in this setting.

Each of these dimensions is subdivided into a number of elements.

The TPI was administered twice within the programme; once at the beginning and again towards the end of the 10-month process. The team representatives were responsible for distributing the forms to their team members on each occasion and returning them to their programme facilitator who sent them to Aston OD Ltd where they were analysed and written reports produced for each team.

The TPI reports were developed by averaging scores from all team members to create 16 dimension scores for each team. These scores were then compared to scores from 92 health care teams. Team scores were described as:

Well below average  | Below average  | Average  | Above average  | Well above average
-------------------|--------------|---------|----------------|----------------------
Bottom 9% of team scores | Next 24% of team scores | Middle 34% of team scores | Next 24% of team scores | Top 9% of team scores

The TPI also reports the level of agreement in the views of team members who completed the questionnaire. For each dimension the level of agreement is shown at one of the following levels:

1 Task design
2 Team effort and skills
3 Organisational support
4 Resources
5 Objectives
6 Reflexivity
7 Participation
8 Task focus
9 Team conflict
10 Creativity and innovation
11 Leadership processes
12 Team member satisfaction
13 Attachment
14 Team effectiveness
15 Inter-team relationships
16 Team innovation

Figure 13 – Dimensions of TPI (Aston Organisation Development Ltd, 2004)
The reports were sent to the programme facilitators, who were responsible for giving the feedback to the team.

The purpose of using the TPI was twofold; primarily as a development tool to provide teams with an assessment of their team effectiveness, and secondly to provide baseline and follow-up data to assess whether there had been any change in team functioning.

The time interval between the two administrations varied from six to nine months with the majority falling in the eight to nine months time frame. While the full extent of team development may not be recognised or achieved within this timescale, it is nevertheless sufficient time to expect some changes.

The dual use of the tool in the programme and the relatively short time gap between administrations does compromise its use as an objective measure of team improvement. However the duration of the programme, delays caused by difficulties in securing local ethical approval and the primary purpose of the programme being development rather than research, led us to make the decision to work within these constraints.

Two types of analysis were conducted. In the first, in order to undertake a comparison of responses at ‘Time 1’ and ‘Time 2’, responses for each component and dimension were aggregated to the team level to calculate the team mean scores. These were then compared using paired-samples t-tests on each component and dimension. The differences reported were the raw team mean score differences, and the significance levels were those for the paired-sample t-tests.

In the second section of analysis, the number of teams with changes (positive or negative) of at least 0.20 on the component or dimension scores was calculated. These were then compared using paired-samples t-tests on each component and dimension. The differences reported were the raw team mean score differences, and the significance levels were those for the paired-sample t-tests.

In terms of reporting, 77 of the teams (76 per cent) completed sufficient valid forms to receive a report at both administrations; 36 teams in cohort 1 and 41 teams in cohort 2. The reasons for individuals and teams not completing the questionnaires varied and included:

- confusion and lack of clarity about actual team membership
- confusion and lack of clarity about how to complete the form
- concerns about confidentiality, especially in relation to team leadership
- cynicism about the tool, the programme and the process
- administrative logistics about distributing the questionnaires, receiving them back and sending them to Aston OD (this was especially true for some of the more geographically dispersed teams)
- delays in securing local ethical approval to administer the TPI
- time and competing priorities.

Figures 14 and 15 illustrate the overall changes in TPI dimensions for the first and second cohorts.

---

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs - overall</strong></td>
<td>3.32 (0.25)</td>
<td>3.43 (0.27)</td>
<td>0.11*</td>
</tr>
<tr>
<td>Task design</td>
<td>3.48 (0.20)</td>
<td>3.54 (0.27)</td>
<td>0.06</td>
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<tr>
<td>Team effort and skills</td>
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<td>3.67 (0.36)</td>
<td>0.11</td>
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<tr>
<td>Organisational support</td>
<td>3.23 (0.32)</td>
<td>3.39 (0.32)</td>
<td>0.16*</td>
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<td>Resources</td>
<td>2.66 (0.51)</td>
<td>2.76 (0.50)</td>
<td>0.10*</td>
</tr>
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<td><strong>Team processes - overall</strong></td>
<td>3.52 (0.35)</td>
<td>3.62 (0.36)</td>
<td>0.11</td>
</tr>
<tr>
<td>Objectives</td>
<td>3.62 (0.30)</td>
<td>3.74 (0.38)</td>
<td>0.12*</td>
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<tr>
<td>Reflexivity</td>
<td>3.30 (0.42)</td>
<td>3.39 (0.40)</td>
<td>0.09</td>
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<tr>
<td>Participation</td>
<td>3.53 (0.42)</td>
<td>3.66 (0.45)</td>
<td>0.13</td>
</tr>
<tr>
<td>Task focus</td>
<td>3.61 (0.36)</td>
<td>3.68 (0.30)</td>
<td>0.06</td>
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<tr>
<td>Team conflict</td>
<td>2.49 (0.45)</td>
<td>2.36 (0.45)</td>
<td>-0.13</td>
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<tr>
<td>Creativity and innovation</td>
<td>3.47 (0.37)</td>
<td>3.58 (0.42)</td>
<td>0.11</td>
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<tr>
<td><strong>Leadership processes - overall</strong></td>
<td>3.57 (0.35)</td>
<td>3.63 (0.48)</td>
<td>0.06</td>
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<tr>
<td>Leading</td>
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<tr>
<td>Managing</td>
<td>3.56 (0.35)</td>
<td>3.58 (0.53)</td>
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<td>Coaching</td>
<td>3.67 (0.38)</td>
<td>3.67 (0.58)</td>
<td>0.00</td>
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<tr>
<td>Leadership clarity</td>
<td>3.42 (0.61)</td>
<td>3.55 (0.65)</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Outputs - overall</strong></td>
<td>3.34 (0.32)</td>
<td>3.43 (0.34)</td>
<td>0.09</td>
</tr>
<tr>
<td>Team member satisfaction</td>
<td>3.51 (0.37)</td>
<td>3.66 (0.40)</td>
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<td>Attachment</td>
<td>3.89 (0.44)</td>
<td>3.88 (0.46)</td>
<td>-0.01</td>
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<td>Team effectiveness</td>
<td>2.91 (0.42)</td>
<td>3.00 (0.42)</td>
<td>0.09</td>
</tr>
<tr>
<td>Inter-team relationships</td>
<td>3.11 (0.33)</td>
<td>3.22 (0.37)</td>
<td>0.11</td>
</tr>
<tr>
<td>Team innovation</td>
<td>3.25 (0.38)</td>
<td>3.32 (0.44)</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Significant differences: * p < .05; ** p < .01
Positive changes for cohort 1 occurred in all but two of the dimensions (coaching remained the same while attachment has reduced). The negative change relating to team conflict indicates a reduction in team conflict. Changes in three of the dimensions are statistically significant; organisational support, resources and objectives.

Positive changes for cohort 2 occurred in all dimensions (again the negative score in team conflict indicates a reduction in conflict) with the change being statistically significant in 17 of the dimensions; attachment and team conflict being the only dimensions where the change is not statistically significant.

Changes at team level

Figures 16 and 17 illustrate how many teams increased by at least 0.20, decreased by at least 0.20, or showed little variation, for each individual dimension and element. The value of 0.20, although fairly arbitrary, is approximately equal to half a standard deviation for many of the dimensions and elements, and so represents a reasonable level of change.
Figures 16 and 17 give a more detailed picture of direction and extent of change in the TPI scores in the different dimensions and elements. In cohort 2, a larger number of teams showed an improvement of at least 0.20 and in several cases, a majority of the teams.

Discussion of TPI results

The TPI provides one aspect of the programme evaluation and it is not within the scope of this report to undertake a detailed analysis of these data. The overall trend demonstrates improvements in team performance from pre- and post-administration of the TPI, with cohort 2 making more statistically significant improvements than cohort 1.

The teams in cohort 1 and 2 were very similar in terms of types of team, the client groups they worked with, the amount of change that was taking place in and around the teams, the roles held by the team representatives and the overall level of support from the organisations. The only obvious difference between the teams in the two cohorts was that of team size, with teams in cohort 2 reporting a smaller team membership than those in cohort 1.

This factor may account for the greater degree of improvement measured in the second cohort teams. The increased confidence of the programme facilitators for the second cohort provides an explanation as to why the second cohort teams were smaller. The second time around, facilitators worked with the teams to identify smaller numbers in the team was likely to make both team working and participation in the CTP a more manageable and effective process. As a result, they were more directive with their guidance and advice to organisations and team representatives concerning numbers.

A further factor that may have contributed to the difference between the cohorts is the fact that programme facilitators had increased familiarity with both the programme and the TPI for the second cohort. It could be argued that by applying their learning from the first cohort the facilitators delivered a more effective programme the second time around. In addition to their general increase in confidence and knowledge of the programme, aspects that the facilitators specifically identified as doing differently on the basis of running the first programme included:

✦ working with teams earlier to identify more manageable and less unwieldy team membership numbers
✦ working to involve the whole team, and not just the team representatives, in the programme as early as possible
✦ increased confidence to work more flexibly within the programme, whilst still maintaining its integrity in order to adapt to local need and context
✦ improved ability to support the effective use of the TPI, for example improved clarity of explanation, greater understanding of its potential use and benefit.

Increased scores in team functioning

The increase in the team functioning scores may be attributed to a range of factors, including participating
in the CTP. Some teams, having invested heavily in the programme, may have scored themselves highly on the second administration in order to demonstrate improvement or show loyalty to their team, their representatives, their managers or their facilitator.

Other factors may also have brought about the change, for example, changes in personnel, other training or development undertaken by the team, organisational changes or simply the passage of time.

**Decreased scores in team functioning**

Figures 16 and 17 show some teams recorded decreased scores in some elements on the second administration. A variety of reasons could account for this. Three are put forward here by way of possible explanation.

**False high scores recorded on first administration**

Some teams and their facilitators felt that the second administration provided a more accurate assessment of their functioning. They held the view that on the first administration, individuals gave over inflated scores. The reasons offered for this were various; some believed that team members were defensive and resentful, feeling they had been ‘sent’ on programme because they were a poorly functioning team and they wanted to prove their managers wrong. Another explanation was a loyalty to the team and a desire not to expose any weaknesses or an anxiety about causing disruption.

As this representative commented:

“My colleagues did not fill in the first TPI as truthfully as they should so as not to upset the apple cart, therefore the feedback did not bring out any of the real points of contention.”

A final understanding of this was that at the start of the programme the teams had done little examination of their own processes or functioning and were working in a state of unconscious unawareness and their ability to effectively critique their own functioning was not developed. They recorded high scores because that was their experience at the time.

By the end of the programme, as the evaluation shows, many teams had developed a much more open, critically reflective and questioning culture and so were less defensive, more able to offer critique without appearing disloyal and more skilled in their ability to critique and thus were more discerning in their scores.

**Change causes disruption and team working is hard**

The CTP is in essence a change programme. Through the processes of the programme, teams examine their ways of working and the focus of their work. They decide they want to do some things differently which means stopping doing some things and doing other things, which is both disruptive and difficult. It is not surprising that some teams experienced a decrease in functioning whilst previous patterns and ways of working were disrupted and before new ones were established.

**External change impacting on the team**

All the teams we worked with were in the midst of, or surrounded by change. For some teams significant changes occurred during the course of the programme which could account for a decrease in team functioning, for example the almost overnight and unexpected closure of the community hospital where two of the teams were based.

**Conclusion**

The relatively short time interval between the administrations of the TPI and the fact that it was used within the programme as a development tool, as well as an evaluative tool, does present some limitations to the validity and reliability of any conclusions drawn.

However using a variety of evaluative data in addition to the TPI, this report presents considerable evidence to suggest that taking part in the CTP did improve team functioning and we concluded that the CTP is a significant factor in accounting for the increased team functioning scores.

**4.2 Impact and outcome reported by team representatives**

The data presented in this section are taken from the evaluation forms team representatives were asked to complete at the end of the programme. The form consisted of a series of questions requiring answers on a Likert scale from 1 to 5, together with space for further comments to provide qualitative data. The majority of those completing the forms did take the opportunity to
provide additional comments (see Appendix 3 for the questions included on the evaluation form).

The evaluation forms were distributed to the representatives by their programme facilitator. We were aware that participants on the programme might find it difficult to offer critical comment so care was taken in the design of the form to enable the representatives to offer both positive and negative comment. In addition, the forms were completed anonymously and returned directly to the RCN central office and not to their facilitators.

A total of 223 forms were distributed (88.5 per cent of all registered team representatives) and 127 were returned, representing a 57 per cent return rate. Every attempt was made to distribute forms to all of the representatives initially registered on the programme, however some had moved jobs, and some were on annual leave, off sick, or were not present when the forms were given out.

The Likert scores were entered onto an SPSS database and charts produced to show the findings. The comments made in relation to each question were transcribed and collated into lists. These lists were then subject to content analysis through a process of coding, categorising, classifying and labelling to produce themes as described by Patton (2002).

In presenting the data the following conventions are used:

✦ titles of themes are given in bold
✦ the number and or percentage of examples coded into each theme is given in brackets
✦ direct quotations are given in italics.

**Findings**

Using a five-point Likert scale, 56.1 per cent of the team representatives reported that the CTP had enabled ‘good’ or ‘great’ improvements to client care and service delivery, 66.7 per cent reported a ‘good’ or ‘great’ contribution to positive changes in their team and 84.8 per cent reported that the CTP had made a ‘good’ or ‘great’ contribution to their personal and professional development.

**4.2.1 Differences to client care and service delivery**

The team representatives were asked whether they thought the programme had contributed to any improvements in service delivery or client care. Their responses are illustrated in Figure 18.

They were also asked to list the improvements and 104 (82 per cent) of representatives provided lists totalling 229 improvements to service delivery. The improvements have been coded and categorised into the following themes:

✦ **More client-centred provision** (60 examples)

Improvements coded into this theme related to communication, understanding and information exchange between service users and the providers of services. These included providing better information based on what users and carers said they wanted to know, including people in decisions about their care, setting up systems to enable access to information such as web sites and to

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**Figure 18 – Programme contribution to improvements in service delivery or client care**

- Not at all
- To a limited extent
- Not sure
- To a good extent
- To a great extent

---
enable discussions between service users and their care providers such as family meetings, patient forums and so on. For example:

“Patients are now involved in the debrief after incidents between other patients or patients and staff.”

“We have established a forum for patients and carers to speak with professionals and ex-users of the service. We get information about their concerns through this.”

✦ More integration within teams and across services (49 examples)

Improvements related to commonality of purpose within and across teams, including the setting of team objectives, establishing joint protocols, policies and procedures across health and social care services, sharing assessment information to reduce duplication and establishing shared records. For example:

“Operational policies more integrated between health and social care.”

“Goals being set jointly by MDT.”

✦ Improvements to the way teams organise service delivery (36 examples)

These improvements related to changing current practices, such as how home visits are organised, how clinics are run, how duty rosters are done, what happens in team meetings and ward rounds. For example:

“We have made changes to the duty system and message taking which has led to increased client satisfaction.”

“We have altered the way the team works as result of patient stories and reduced the number of different people going into clients’ homes.”

✦ Taking a different approach (30 examples)

These changes related to how team members communicate about their work and the service. They include more open critical questioning of each other, the giving of direct feedback about performance and the establishment of clinical supervision. For example:

“Colleagues are now much more able to discuss case work together in a ‘no blame’ way – this leads to better care.”

“Giving feedback directly to individuals has improved performance.”

✦ Increased access to a range of services (26 examples)

Changes in this theme related to creatively increasing access to available resources. Improvements involved better provision of therapy groups, skill mix reviews and the introduction of new roles, such as housekeeper or technical instructor, or extending the roles of existing members, relocation of team members to increase access or pooling budgets to increase available finance. For example:

“Intermediate care support workers have been relocated from Social Services department to the community hospital increasing access for clients.”

“The number of standard wheelchair clinics has increased.”

✦ Improvements to the client pathway (18 examples)

These largely related to changes in transition moments between services such as assessment, admission, discharge and referral. For example:

“Common assessment framework introduced (between health and social care) to improve communication between service providers and give better support for families with complex needs.”

“Referral processes are more deliberate and planned – more of a team focus – duplication reduced. Clearer client pathways.”

✦ Improved meal times (10 examples)

For example:

“GPs now do ward rounds at allocated times so as not to disrupt meal times.”

“A designated dining area has been developed.”

There were also many examples of improvements to the environment of care, including reducing infection risk, reducing noise levels, making clinics and waiting areas more pleasant places to be, providing hot drinks, pictures, clear signposting etc.

The following case studies provide some examples of the service improvements and indicate the ways in which the CTP supported these changes to take place.
Case study 1 – Creating specialist provision for patients following a stroke (taken from an impact sheet5)

The team
Ward-based team in a community hospital with specialist beds for people who have had a stroke.

The issue
There were initially two wards with stroke patients who were randomly allocated to either ward, with no continuity of care for patients. There was no specific training for staff in the care of these patients.

The solution
There is now one ward with all the stroke patients who are allocated into two bays of reserved beds. There is one team to care for these patients and staff members rotate into this team, to ensure their skills are updated.

How was it achieved?
Team representatives were empowered through the workshops, and specifically the action learning sets, to look at the research and ask for a management meeting. Their background research enabled them to take a more strategic view. They went to the management meeting with a sound case prepared; this enabled them to question the managers’ initial decisions. This resulted in a new decision to amalgamate the stroke beds and redesign one ward, close some beds and utilise this money to add additional capacity to the discharge team to speed up discharge and improve rehabilitation in the community.

The steering group for the CTP supported this and the money was transferred to develop this one new ward.

What positive difference has it made to patient care or services?
There is now a designated team for the care of patients following a stroke. There is better continuity of care. Training schemes are designed and ready to be put into action in June 2005, following the team event day. There is smoother discharge planning into the rehabilitation service as MDT meetings now specifically focus on client case work and are held more frequently.

It is better for patients, as research shows that recovery rates are improved for people who are nursed in specialist stroke units. The new unit is a bright, welcoming environment and patients have written to the local newspaper to say the service is excellent.

It is too early yet to say if discharge is quicker into the community, but people are coming to the community hospital from the acute hospital more quickly – less than 10 days.

What were the financial implications?
The cost of the rebuild will be significant. There has been no staff redundancy, but there has been a loss of staff due to natural wastage. Additional staffing costs have been transferred to a rehabilitation service. There are potential savings from early discharge into the community and savings for early discharge from the acute hospital and greater through-put of patients with specialist care needs.

Which strategic agendas does this address?
NSF for Older Peoples Services
Financial Recovery Plan
Clinical Guidelines for Stroke (Royal College of Physicians)
NSF Coronary Heart Disease
The Essence of Care

5 The completion of ‘impact sheets’ was a method used by the programme facilitators to capture in greater detail any improvements made to services, which were in part attributable to the CTP.
Case Study 2 – Improved meal times using patient stories and observations

The team
A community hospital caring for older adults, supported by GP surgery and therapists.

The issue
Through a patient story, a patient spoke about her unhappiness relating to the meal time arrangements, particularly at lunch time. She spoke about noise, rudeness, being rushed to finish meals, taking meals away from patients before they had finished and not helping those in need.

This was followed up by undertaking an observation at lunchtime. It was observed that the domestic staff were very “gossipy” and indiscreet with general patient information and that water was put in a large jug, but not poured into glasses and many of the patients couldn’t reach it or lift it. All the issues raised in the patient story were confirmed.

What has happened as a result
Now there is a dedicated meal time, with staff allocated to support the patients. Those that are able, come to the table. Some patients are wheeled into the day room in their beds if appropriate. The television is off. Meals are served with a more personal touch from the trolley and not dished up in the kitchen. Everyone has water in a glass and help is available for everyone to eat.

Fifteen minutes have been added to the domestic shift at lunch time to allow more time to finish meals and clear away, so there is less rush. This has been financed from a staff vacancy. All staff talk directly with the patients and not with each other in a gossipy way during meal times.

The amount of food being eaten is noticeably greater and waste has reduced. Staff can observe how much people are eating more accurately and thus assess and document more effectively.

There is increased opportunity to get to know the individual patients, as more time is spent talking with them. This has aided more personalised discharge planning.

Domestic staff feel more valued and have said so.

A review of the meal time approach by a simple patient survey has shown an increase in their satisfaction. The original patient who told her story has been re-admitted and said there was a noticeable improvement.

4.2.2 Differences for teams

The representatives were asked to record on a Likert scale the extent to which they felt the programme had contributed to any positive changes or developments in their team. The responses are illustrated in Figure 19.

They were also asked to list the improvements and 116 (91 per cent) representatives provided lists totalling 354 changes in their teams. The improvements have been grouped into the following themes:

- More open dialogue and critical reflection (93 comments) including more effectively working with conflict (13 comments) “There is decreased conflict, we resolve it better, we are able to challenge each other constructively. Much more open, honest and frank discussion takes place allowing positive results.”

- Increased understanding and sense of ‘team’ (57 comments) “Disciplines are working better together, planning care together and setting goals together.”

- More proactive – action-oriented (41 comments) “We feel empowered to make decisions and move things forward without waiting for it to happen.”

- Increased morale and motivation. (40 comments) “Team spirit renewed – we felt broken as we were scattered, now we are reunited.”

- Increased involvement of everyone in the team (35 comments) “Quieter members have become stronger and stronger members listen more.”
Clearer about own role and contribution and that of others (29 comments) “We are learning how to depend on each other and appreciate each other’s ideas and skills.”

Improved relationship between teams and agencies (19 comments) “Differences between health and social services highlighted and understood.”

Changes to team processes and structures (17 comments) “More organised and productive team meetings with full team involvement.”

Increased leadership (8 comments) “Team leadership clearer – we have a leader.”

Increased awareness of the bigger picture (6 comments) “Actively consider the wider agenda when setting priorities.”

Little or no change (9 comments) “Changes have been limited due to staff changes over the course of the programme and many locums.”

Case study 3 provides an example that illustrates the changes occurring within teams.

Case study 3 – Better working across teams and agencies (taken from an impact sheet)

The teams
1. Intermediate care team: an interdisciplinary team providing short term, high impact rehabilitation and care.
2. Joint care team: an integrated health and social care team for commissioning care.
3. District nursing team.

All teams work in the same areas and work with many of the same patients.

What was happening
There was conflict between the teams and within the teams, as reported by the team representatives and the results of the TPI. There was little help across the teams at times of high demand.

Some members felt unwelcome when visiting the other team areas and the communication was strained. The team representatives reported examples of negative attitudes and action between the teams, for example: “I don’t know them, how can I refer to them?” and “They get all the money, let them do it.”

As a result, there was overlap of visits to patients’ homes. Patient choice was reduced because staff held onto patients, not referring on to the most suitable service. Staff felt stressed due to lack of support at crisis times.

Continued
4.2.3 Benefits

The representatives were asked to identify on a Likert scale the extent to which the programme contributed to their personal development and these responses are illustrated in Figure 20.

They were also asked to list the areas in which their development had taken place; 107 representatives made 386 comments. These are grouped into the following themes:

✦ **Gained new knowledge and skills** (114 comments)
✦ **Work better with others** (88 comments)
✦ **Greater sense of own power and ability to influence change** (61 comments)
✦ **A changed approach to change** (57 comments)
✦ **Improved leadership capabilities** (37 comments)
✦ **Seeing the bigger picture** (19 comments)
✦ **Helped in career planning** (10 comments).

4.3 Impact and outcome as reported by programme sponsors

Sponsors in each organisation participating in the programme were invited to take part in telephone interviews as part of the evaluation. These individuals had been involved in submitting the original application...
to take part in the programme and had management responsibility for overseeing the progress of the programme in their organisation. Sponsors were not core members of the teams involved and were not involved in the workshops or action learning sets. Many of them attended some, or part, of the team events and many were involved in a programme steering group.

The interviews took place in the first three months of completing the programme; 17 interviews were undertaken from the first cohort and 19 from the second cohort, making a total of 36 interviews.

The interviews were conducted by the project lead and two of the programme facilitators. The programme facilitators did not interview the sponsors from the organisations where they facilitated the programme.

Sponsors received a letter explaining the purpose and focus of the interview with an outline of the areas to be discussed. The project administrator then contacted the sponsor to arrange a convenient time for the interview. Where teams were taking part in an inter-agency programme, sponsors from each organisation were contacted for interview. No one refused to take part in the interview, although it was not possible to arrange interviews within the timeframe of the project with seven of the sponsors because of sickness, annual leave and changing roles.

Interviews were also conducted with sponsors from the organisations where teams withdrew from the programme.

Each interview lasted between 30 and 45 minutes.

The interviews were semi-structured and explored the following issues with sponsors:

✦ their overall impression of the programme
✦ any challenges they had encountered in participating
✦ any benefits for service users, teams or individuals
✦ the extent to which the programme had supported any local or national policy initiatives.

The interviews were tape recorded and the tapes transcribed. The transcripts were then subject to content analysis through a process of coding, categorising, classifying and labelling as described by Patton (2002).

Organisational roles of the sponsors

5 Managers of integrated service delivery (four employed by social services)
5 Directors/assistant directors of nursing
4 Intermediate care managers
4 Directors of service improvement/service modernisation
3 Directors/assistant directors of service delivery
3 Directors of older people's services
2 Modern matrons
2 Heads of education and practice development
1 Nurse consultant for older people
1 Deputy director of workforce and learning

Figure 20 – Programme contribution to your personal or professional development

![Figure 20](image-url)
4.3.1 Overall impression

The sponsors were asked about their overall impression of the programme. The vast majority (89 per cent) thought it was excellent, saying that it had been ‘invaluable’, ‘exceptionally worthwhile’ and ‘hugely beneficial’.

Ten of the sponsors said it was not what they had expected. It was less directive and more challenging than they imagined. They also said that it was more skills-based and client-centred than other team development programmes they knew. Although not what they had expected, these sponsors were pleased with the different focus and approach of the programme.

For two of the sponsors the programme got off to a rocky start, with difficulty getting teams to sign up and lack of clarity about purpose and direction of the programme. Both of these sponsors said that it had worked out well in the end once these initial teething problems had been resolved.

The two sponsors from the organisations that withdrew from the programme had initially held high hopes and were disappointed that the teams had not been able to complete.

One sponsor reported mixed opinions, saying that some people had found it useful and others were not sure that the gains outweighed the time and commitment required. Another felt the programme had been very good, but expressed disappointment that some of the teams that they had originally hoped would take part had not done so.

4.3.2 Benefits

All sponsors were able to identify benefits to individuals and all except one (from one of the organisations that withdrew) could identify benefits to teams and service users, and 91 per cent were able to identify organisational benefit.

Of the responses, 24 sponsors said it had helped people look at things differently, enabling people to challenge practice and challenge thinking, and helped look at complex issues:

“*I think it was beneficial for all of the staff to be thinking a different way. I think it was beneficial from the point of view that it recognised individuals. It valued people and their opinions. Very much so, even though they were challenged.*” (C2S14)

In addition 19 sponsors said it had helped through some difficult processes.

One sponsor commented about the move to an integrated intermediate care service:

“It’s been very painful and there was a lot of anxiety, there was a lot of anger at the beginning but by the time we’ve come through to the end people are very pleased with the system now and very pleased with what it’s offering. So, some of our really sceptical professionals right at the beginning are now very happy and I think having the Clinical Teams Programme has helped them through that.” (C1S2)

Furthermore, 18 sponsors said it had improved integration between health and social care and it had brought key people together:

“I have to say that the programme certainly acted as a lever, and certainly brought the heads of the services together, which was good.” (C2S5)

In addition, 17 sponsors talked of the benefits of people from different teams, organisations and disciplines learning together and how this had really helped in the understanding of roles and cultures:

“To us, this whole intermediate care team work is very new and the joining up of social services and health was very new, so it was excellent in terms of facilitating the work that we had already started. In terms of developing those relationships, networking, and understanding better about how patients move between each one was very beneficial. Not just roles, I mean we’re talking about – we had hospital teams, social services teams, and PCT teams. So it’s organisational cultures, its team objectives and where they fit within each of the different organisations.” (C2S2)

Furthermore 15 sponsors said it had taken them
through a **period of transition** and moved from closed to much more open teams:

“It’s [the CTP] been very supportive in taking us through the transition from changing from our closed re-ablement teams into much more open joint intermediate care teams in health and social services. And I think it’s supported us through that process, we were breaking up old closed teams and re-creating much more open, wider teams with a different focus and a whole different way of working.” (C1S2)

In addition 12 of the sponsors said it had **helped them do their job**, for example:

“Myself and my assistant team manager, we would have had to have done a lot of that kind of team building work anyway. So really for us it came at a great time and has been extremely valuable really.” (C1S5)

Also two sponsors said it had **uncovered issues** around quality of care that really needed addressing and now something had been done:

“But because of the issues identified within the team make-up, we found out there were clinical issues and by addressing the way that team is – because of what was found out through the Clinical Teams Programme – then obviously we have been able to do something about it.” (C1S7)

One sponsor stated it had provided some concrete examples of things that had worked in the trust and they could now take these across the organisation, and another said it had been useful to try out some ideas around the management of long term conditions and provided useful learning for the organisation.

**4.3.3 Improvements for clients and service delivery**

Seventeen of the sponsors talked about many **small changes that make a big difference** to service users. These included increased confidentiality by providing private spaces, improvements around mealtimes, environmental changes:

“I think as professionals sometimes you think you do involve patients and that you advocate for patients, but I think where the light bulb switched on was actually things that people hadn’t thought about, so it was only small things, around small environmental issues. Well in our view, minor things but obviously the minor things were quite important to patients.” (C1S9)

“There has been a lot of simple stuff that came out of it, but the funny thing is that, when you work every day in an environment you obviously get de-sensitised to the everyday problems that you see, or that you don’t see probably. And just taking time out, just to reflect on a day’s work, and looking at diaries and that sort of the thing, makes you realize how simple some of the problems are to solve.” (C2S19)

In addition, 16 mentioned **improvements in achieving targets**. For example:

“During the life of the programme we have shifted the number of people we see on a day-care basis from 37 per cent to 62 per cent. This was championed by one of the consultant surgeons.” (C1S17)

“There were around 2,500 outstanding cytology specimens awaiting reporting – way outside the national guidance. The processes were examined and changes implemented through the programme and within two and a half months we were down to 52.” (C1S17)

“Our month-on-month data show that some of the performance indicators we have are around care plans and reviews and carer’s assessments and direct payments are being much better met than 10 months ago.” (C1S5)

Thirteen sponsors mentioned **improvements to care pathways**. As with the team representatives they reported improvements around moments of transition, for example assessment, referral, admission and discharge. An example of this is illustrated in Case study 4.
Ten sponsors talked about **increased access to different services** for example, increased access to social workers, new therapy groups established and groups being set up between health and social care in school and other educational settings, getting equipment into people’s homes more quickly:

“We’ve got community care workers based out with us now for two days a week – as a direct result of the programme. This means that families and patients who want to look at nursing homes, or residential homes, or services and domiciliary care, and need help through financial assessments can get this much more quickly. They can have person to person access, rather than it being remote from a central office, they can just pop in the hospital and talk to them.” (C2S6)

Nine mentioned **improvements to ‘customer care’** resulting in reduced complaints and increased positive feedback:

“I think for me there were probably two very clear messages. One was around the impact it had had on patient care, and the fact that those that participated, because they had done the patient stories and the observations, very clearly had become far more patient-focused and quality-focused. Almost to the extent where they saw themselves as delivering a service to a customer. It was almost that recognition that they had a responsibility to act on things that were not right.” (C2S15)

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**Case study 4 – Improvements to client pathway (taken from sponsor interview C2S5)**

**Sponsor**

We’ve developed the rapid response team as a direct result of the programme. Practitioners in the different teams, the intermediate care team, the community hospital and the community nursing team were saying that people were being admitted to hospital because it wasn’t possible to get a quick enough response in the community.

We have agreed different pathways with the ambulance service so now if they get a 999 call for someone who has had a fall, they will call the rapid response team who will go and undertake a full assessment. We’ve changed the structures so that the team can access and put in place services immediately. For example, they can get equipment directly or can organise for someone to be with the person. Previously the ambulance would have taken them to the acute hospital where they would have been for a few days then transferred to the community hospital and then many ended up in long term care.

**Interviewer**

How did the programme help bring this about?

**Sponsor**

Because it brought all those different people, who are normally squabbling, in a room, together and they suddenly realised that the people over whom they had the most arguments, if you like, they all shared the same view that these people were actually being disadvantaged by the way that the services were organised. Actually, the problem was that there was a big hole that they were all trying to paper over. That was when they started drawing their pathways, and saying well this is what happens now, and this is what we think should happen.

**Interviewer**

Was this relatively straightforward?

**Sponsor**

Well I think in fairness, probably no. I vividly remember it, because it was in a steering group, when the facilitator talked about the need for people to work flexibly around the needs of the patient, instead of being so bound into their criteria etc., and I can remember the look on their faces, and I was thinking, goodness – this is crunch time, when people suddenly realise, you could see the ‘ah, but…’ in their faces. And I think that was when we realised collectively that actually we’re going to have to do something different, because it won’t work if we just tried to make the existing systems work differently.
Seven reported that there had been a lot of work around quality improvement.

4.3.4 What the sponsors said about the teams

The sponsors also identified changes within the teams that took part. The most commonly cited changes were within the overarching theme of teams being more proactive and action-orientated. Twenty-seven of the sponsors mentioned this, talking about a change of culture within the teams that had taken part. They spoke of an increased ownership of change within the teams, that they were empowered to take action, had gained confidence and been provided with some of the tools to make changes happen. They were more willing to take risks, less passive and more challenging in constructive ways. They also felt that the teams had greater clarity of purpose and direction:

“The team is very much more able to cope with different demands and I don’t think there is any doubt that a lot of it has had to do with the Clinical Teams Programme, in terms of getting the team working much better together, accepting that you have to have targets and addressing them and then working out ways of how to meet those targets. So there’s a much greater flexibility. If I’d given those targets to them, say, 12 months ago I think we’d have had a much more of a kind of a ‘no way’ response, whereas now it’s a ‘can do’ approach.” (C1S5)

“The team was disjointed and there were some morale issues. But because they participated in the program they began to find out how powerful they were as a team and they have been able to change and influence the way services are delivered. Not only on their own unit, but over wards across the hospital.” (C1S7)

Twenty-eight said that the teams were working differently in terms of the way team members interact with each other, they were thinking more laterally, involving more people from within the team and with people from different teams and different agencies and were more aware of the bigger picture. They perceived the teams to be more supportive of each other with increased flexibility and less friction.

As one of the sponsors said:

“There is much more tolerance, respect and understanding between the different team members and of their colleagues from other agencies. Now you might find a nurse explaining to another nurse why social services couldn’t do something, whereas in the past, they wouldn’t have known that – or certainly wouldn’t have expressed it.” (C2S12)

Twenty-two of the sponsors talked about increased clarity and more effective leadership in the teams and more people taking on leadership roles. Twenty talked about barriers being eroded between professions, between teams and between organisations. This was coupled with an increased understanding of their own role and the roles of others:

“We’ve got one outstanding person that was one of our OTs basically, of the hospital, who has taken off quite big style really, and will probably get promoted quite soon. And she’s the person that’s been the key, and the glue in keeping people together. She’s still taking a lot on, and is being asked to do a lot more from outside.” (C2S6)

“There seems to be closer working with the therapists. They are definitely sharing the problems with the nurses; the ward problem is not just the nurses’ problem now. A therapist will come in and the ward staff will go to the therapist to ask for advice, not necessarily about therapy issues but about general issues in the ward. There is definitely a better togetherness, if I can put it that way.” (C2S19)

4.3.5 Changes for individuals

All but one of the sponsors identified personal and professional development for individual team representatives. They talked about increased confidence, increased engagement and involvement. They were more proactive, asked more questions and acted as change agents. Fifteen mentioned that it had enabled new lights to shine.

A sponsor comments on one nurse’s development:

“One of the nurses has been very actively involved in Essence of Care and she had the opportunity this year when the matron went on maternity leave to lead the whole of the Essence of Care programme for the community hospital. Before she was very cynical, just came in and did her job, the difference in her behaviour, her communication skills, her attitude is just phenomenal. And everybody’s noticed it, it’s really, really, really good.” (C1S3)
4.3.6 Contribution to local and national policy agendas

Seventeen of the sponsors mentioned ways in which or gave examples of how learning from the programme had been taken to other parts of the organisation that had not taken part in the programme.

As one sponsor said:

“We have been trying to bring three cultures together across the organisation. What we were hoping was that this Clinical Teams Programme would give us more people that would actually start building that critical mass. Because the programme’s longer and I think we’ve been encouraging people to put things into practice so that the behaviours and their confidence become normal. But actually that rubs off on others. I’ve noticed people who’ve done the Leo programme who didn’t feel that they could do anything, suddenly they seem to be re-ignited and sort of coalescing around the clinical teams people, so we’ve started to get this critical mass rolling.” (C1S3)

Between them the sponsors identified 63 local or national strategic agendas that the CTP had helped support. Two of the 36 sponsors did not identify anything in response to this question. One of these stated that her PCT did not have any strategic direction and the other was from one of the organisations that withdrew. The policy agendas to which the CTP contributed are illustrated in Figure 21.

Figure 21 – CTP contribution to policy agendas

<table>
<thead>
<tr>
<th>Policy agenda</th>
<th>Number of times mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Public Involvement</td>
<td>10</td>
</tr>
<tr>
<td>Integration of health and social care</td>
<td>10</td>
</tr>
<tr>
<td>Leadership and management strategy</td>
<td>7</td>
</tr>
<tr>
<td>Development of services in the community</td>
<td>5</td>
</tr>
<tr>
<td>Long term conditions strategy</td>
<td>4</td>
</tr>
<tr>
<td>National service frameworks</td>
<td>4</td>
</tr>
<tr>
<td>Valuing People</td>
<td>4</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>4</td>
</tr>
<tr>
<td>The Essence of Care</td>
<td>3</td>
</tr>
<tr>
<td>Improving Working Lives</td>
<td>2</td>
</tr>
<tr>
<td>Organisational development strategy</td>
<td>1</td>
</tr>
<tr>
<td>Service development for stroke services</td>
<td>1</td>
</tr>
<tr>
<td>Developed a group of people to drive the whole modernisation agenda</td>
<td>1</td>
</tr>
<tr>
<td>Introduction of meaningful performance indicators owned by staff</td>
<td>1</td>
</tr>
<tr>
<td>Standards for Better Health</td>
<td>1</td>
</tr>
<tr>
<td>Admission avoidance</td>
<td>1</td>
</tr>
<tr>
<td>Shared governance</td>
<td>1</td>
</tr>
</tbody>
</table>

4.3.7 Challenges experienced by the sponsors

Whilst there were many benefits to taking part in the programme, there were also challenges. We asked the sponsors to talk about these.

Securing time to release staff to attend the different elements of the programme was the most frequently mentioned, with 31 of the 36 sponsors reporting this. Seven people also identified the lack of funding for backfill and having to fund catering and venues for the programme activities.

“I think that time and resources are always a difficulty for busy teams, so that has been a challenge. I think also in terms of organisation, initially we didn’t do enough with the teams prior to the programme starting to understand the commitment and what the programme was about.” (C2S10)

The next most commonly cited issue (by 13 sponsors) was the nature of the process itself. These discussions focused on the sometimes difficult and painful processes involved in exploring team dynamics and culture and in embarking on a journey of reflection, critique and change. One sponsor commented:

“Sometimes it felt like stirring a pot that didn’t need stirring.” (C1S6)

Another talked about conflict in the team:

“I think there was an awful lot of conflict within the team and this came to the fore in the first few meetings. This was challenged by the facilitator, and I’m not sure that they were actually really ready to deal with that. They put a lot of blame onto the facilitator. Now they have actually said to us that they could see that the problem was with them, and the conflict was actually in the team and the facilitator was doing her job, and doing it very well. The benefit for them has been that they’ve now actually been able to talk about the conflict within the team. The conflict is still there, but they’re actually channelling it in the right way now, and they’re using it as a positive, rather than a negative, and using each other’s strengths to support each other.” (C2S8)

This is linked to the next most frequently mentioned issue (by 12 people) that of actually implementing change or doing something different or differently once it has been recognised as necessary. The challenge of going through this process with teams from different cultures (such as health and social care) was
mentioned by eight of the sponsors:

“It was a particular challenge because we were so embryonic when the programme started; we’d only literally started to pull them together six months previously. It was a very difficult cultural shift for people. For instance health visitors have always worked with GP practices within primary care as autonomous workers. We have created multi-disciplinary integrated Children and Family Teams in geographical areas. There was a certain amount of anxiety about being asked to work in a team, to work with a skill mix with school nurses, health visitors, staff nurses, nursery nurses and healthcare support workers. So it is a major cultural shift for some members of staff. This program helped us to unpick some of the issues and to spend time working on it.” (C2S1)

Possibly because of some of these other challenges, 11 of the sponsors talked about the challenge of maintaining motivation and commitment throughout the programme:

“It has been in patches, if you know what I mean. There were days when they were really motivated and then when the work pressure kicks in and other things kick in, it is almost like they forget about the programme.” (C2S19)

Different issues relating to the role of the team representative were also identified as challenging. Eight sponsors talked about selecting the ‘right’ team representatives. The issue of what is a ‘right’ team representative will be picked up in the discussion section of this report. Seven people mentioned the big responsibilities of the role and the difficulty of getting the whole team involved. Two said that the team representatives were seen by others as ‘special’ and this had raised some challenges.

“I think it was, from our point of view, in getting the right sort of champions and the people actually in the action learning sets was our biggest challenge, and people feeling that this was an appropriate use of their time, and a good thing to do. That was our biggest challenge.” (C2S6)

Two sponsors talked about the fact that the teams taking part felt that they had been ‘sent’ because of poor performance and this had created difficulties in their motivation.

Five people felt that not enough information about the programme was given at the beginning and that there had been a very short lead-in time to prepare. Three commented that it had taken some time for everyone in the teams to establish a good working rapport with their facilitator and for one or two individuals (programme participants, not sponsors) this had never happened:

“Probably one of the biggest challenges was the facilitation style, which I’m not sure was entirely right for clinicians. When you’re working with groups of clinical practitioners who are used to a fairly directive way of working, not having that amount of direction can be quite challenging. In some ways, it worked very well because as a result of that, they had to learn how to fend for themselves a bit, and it developed them as a team a lot. But it was difficult for them.” (C2S7)

Two felt that the programme was not sufficiently flexible to meet local constraints and challenges. Two also commented on the difficulties encountered in securing local ethics approval to undertake patient stories.
5. CTP content, process and structure evaluation

This chapter presents the findings from the data gathered in relation to content, structure and process of the CTP. These data are taken from the evaluation forms completed by the team representatives – see Appendix 3.

5.1 The role of the team representatives

Each team taking part in the CTP was asked to select two or three team representatives to lead the programme in their teams. Information about the role and an outline of the experience and qualities necessary for the role were provided by the RCN project team. Whilst the programme facilitators offered support and guidance on the selection of team representatives, the final decisions were left to the teams and the organisations.

Figure 22 presents the information that teams were given by their programme facilitators to help them make their selection for team representatives.

The selection process occurred in a wide variety of ways across the 107 teams, from conscription to democratic election. Some of the larger teams supported more team representatives and some teams were only able to support one representative.

The role of team representative was crucial within the CTP. They attended all elements of the programme, that is the workshops, action learning sets and team events. They held a key role in getting the rest of their team involved and taking the learning from the workshops and learning sets back to the team, and working with them to plan and implement changes.

Figure 22 – Information given to teams to help in the selection of team representatives

<table>
<thead>
<tr>
<th>Suggested qualities and experience for team representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ The individual must be willing to take on the role.</td>
</tr>
<tr>
<td>✦ They need to be able to take time away from the clinical or service area to attend workshops and monthly action learning sets.</td>
</tr>
<tr>
<td>✦ This is a multidisciplinary programme; it is therefore beneficial to nominate team representatives from different disciplines within the team.</td>
</tr>
<tr>
<td>✦ In order for the programme to be successful, it is important that the team representatives have authority and credibility within the team. This should come from a) line managers and team leaders b) other team members c) within the individuals themselves. It includes being able to access appropriate meetings and resources and having the support of others through their active participation in the programme.</td>
</tr>
</tbody>
</table>

In addition to the above it is important that the team representatives have the following attributes:

✦ holds those who use the services and their carers as central to the delivery of health and social care
✦ a flexible approach
✦ demonstrates empathy and respect for others
✦ open to change
✦ able to motivate others
✦ able to negotiate and challenge effectively
✦ able to articulate ideas clearly.

Through the workshops and action learning sets using the Leadership Qualities Framework (DH, 2003) as a guide, the team representatives have the opportunity to develop these capabilities further. They are not expected to be experts in everything straight away. However if those who use the service, the individual representative, the team and the wider organisation are to gain the most from this programme, nominating and supporting representatives with these capabilities will be crucial.
This section reports on the programme evaluation by the team representatives. Data were taken from the evaluation forms they were asked to complete at the end of the programme (see Appendix 3). The form consisted of a series of questions requiring answers on a Likert scale, together with space for further comments to provide qualitative data.

5.2 The experience of the team representatives

The role of the team representative was to take a lead for taking the programme forward within their teams. This included:

✦ engaging their team colleagues in the team development and service improvement activities of the CTP
✦ co-ordinating the distribution and return of the TPI questionnaires
✦ undertaking patient stories
✦ undertaking observations
✦ planning, and in many cases co-facilitating, team events.

The content, process and structure of the CTP were designed to support the team representatives in their role.

The team representatives were asked for any comments they had about the role. The following themes emerged from an analysis of their comments:

An enjoyable and worthwhile role (55 comments)

“I felt very privileged to be a team rep. It gave me a lot personally and professionally. It was an honour.”

“A fulfilling and rewarding journey. Made me aware of my capability and the impact we can have on each other at work.”

“A unique opportunity to make a difference.”

“I learnt a lot. I’m now at university training to become a nurse. I’m using some of the skills learnt to help other students. It has also given me confidence to become group rep in my cohort.”

Hard work and challenging (15 comments)

“It felt like an uphill struggle at times, however when the results and the success could be seen it was worth the effort made.”

“I enjoyed the experience – it has been a battle to challenge culture which is isolating at times.”

“It’s well worth being a rep but you need stamina and perseverance.”

Interpersonal dynamics stimulated by taking up the role (8 comments)

“Personal development achieved. I wouldn’t do it again because hostility from the team has hampered progress.”

“I felt guilty about taking part whilst others in the team were left behind.”

“Colleagues didn’t understand and there were lots of misperceptions what it was about.”

“Some team members viewed it as skiving.”

“At times it felt like a battle between managers and the team and us reps got caught in the middle.”

Many of the representatives also reflected on what they saw as crucial to ensure a successful programme and what they might do differently next time. These comments were categorised into a theme labelled ‘keys for success’.

Keys for success (27 comments)

The comments below encapsulate the key issues within this theme.

✦ Needing time and support.

“Having three team reps was really important.”

“The appointment of new supportive manager 1 month before programme started was essential to the success.”

“Team reps need to be given required time to fully implement programme.”

✦ The importance of preparation and adequate information for the right people before starting.

“The key to being successful was ensuring people understood the programme and how you as a rep fit into the big picture.”

“Would have liked more links back to whole team – perhaps facilitators doing an initial briefing for whole team and managers would be good.”
“The wider social services team needs to be aware of purpose of programme.”

✦ The nature of change and how best to work with it.

“Given time again I would involve whole team in some way right from start and regularly.”

“Change does not come easily to most teams. Initiatives have to be introduced gradually.”

“Need to ensure that changes occur naturally to the team rather than overtly under banner of Clinical Teams Programme.”

“Important to address negativity in an open way to enable the person to come up with ways of changing.”

Thus we get a picture of a challenging role that is hard work and in most instances rewarding and worthwhile.

**Specific tasks associated with the role or team representative**

The representatives were also asked whether or not they had been able to:

✦ undertake patient stories

✦ undertake observations

✦ get the rest of the team involved

✦ develop action plans

✦ implement action plans.

Their responses are illustrated in Figure 23, Figure 24, Figure 25, Figure 26 and Figure 27.

There was roughly an 80/20 split in each area between those that were able to achieve the particular task and those that could not. The evaluation forms from which these data were taken were completed by individual representatives. It is therefore the individual saying that they personally were or were not able to undertake these particular activities. Stories, observations and team events took place in all the teams who completed the programme.

More of the team representatives were able to undertake observations than stories. The issues in some organisations for gaining local ethical approval (MREC approval had been gained) and the logistics of and anxiety aroused by doing the stories may account for this difference.

### 5.3 Evaluation of workshops

The team representatives were asked to score on Likert scales the extent to which the workshop element of the programme supported them in their role and provided ideas to take back to their teams.

The representatives were also asked about the workshops in relation to their own personal and professional development and as a space for discussion and sharing ideas.

Their responses are illustrated in Figures 28, 29, 30, and 31.
Figure 28 – The extent to which the workshops were useful in supporting you in your role as team representative

Figure 29 – The extent to which the workshops were useful in providing ideas for taking the work back to your team

Figure 30 – The extent to which the workshops were useful in supporting your own personal/professional development
Qualitative comments about the workshops

Representatives were asked for any other comments about the workshops. One hundred and twenty eight comments were made by 70 representatives. The comments were coded and categorised into the following themes:

- **a good learning culture** (37 comments) "A great culture was created for open and honest discussion."

- **meeting and learning with others** (25 comments) "Sharing ideas in a multidisciplinary context was very useful."

- **relevant and interesting content** (19 comments) "Useful/informative, comprehensive, very good."

- **a worthwhile and enjoyable experience** (17 comments) "Informative thought provoking and fun."

- **came together as it progressed** (12 comments) "Now we have done the work it all makes sense – the pieces have now been fitted together."

- **critical or negative** (9 comments) "Sometimes a bit top heavy on jargon and handouts. More structure would have provided more direction."

5.4 Evaluation of action learning

In relation to action learning sets, the representatives were asked how useful they had been:

- to support them in their roles as team representatives (Figure 32)

- to develop action plans for the team (Figure 33)

- to implement the action plans (Figure 34)

- for their own personal development (Figure 35).

Figure 31 – The extent to which the workshops were useful as a space for dialogue and sharing ideas

![Graph showing the extent to which the workshops were useful as a space for dialogue and sharing ideas.](image-url)
Figure 32 – The extent to which action learning sets were useful in supporting you in your role as team representative

Figure 33 – The extent to which action learning sets were useful in supporting you in developing action plans for your team

Figure 34 – The extent to which action learning sets were useful in supporting you in the implementation of action plans
Qualitative comments about action learning

Ninety four individuals offered 159 additional comments about action learning. These comments were coded and categorized into the following themes:

✦ **an excellent process** (33 comments)
  
  “I found these revolutionary. I was apprehensive and felt vulnerable about presenting but the sessions were fantastic – helped me grow as a person, a professional and team player.”
  
  “Opened my mind to really deep problem solving.”

✦ **getting things done** (26 comments)
  
  “Helped clarify issues so I could see what was going on and move forward.”
  
  “Target dates gave me the push to get going.”

✦ **made me aware and changed the way I do things** (23 comments)
  
  “Made me aware of my need to rescue people.”
  
  “Has totally changed my questioning style.”

✦ **demanding and challenging** (19 comments)
  
  “My first experience of ALS I found it emotionally draining.”
  
  “Hard not to give advice and impose my opinion on others.”

✦ **a safe learning environment** (16 comments)
  
  “Created a space for free thinking and speech.”
  
  “Good facilitation made me feel safe.”

✦ **working and learning with others** (13 comments)
  
  “Great to work across professional and organisational boundaries.”
  
  “Allowed us to form close relationships and provide support back in the workplace.”

✦ **structural/membership issues** (12 comments)
  
  “Fewer sets but longer might be better – difficult to get time away.”
  
  “Composition of the set influenced what I felt able to discuss as my team leader was in the set.”

✦ **a negative or disappointing experience** (10 comments)
  
  “We were made to feel we had to participate, did not feel at ease and felt my personal feelings were overridden.”
  
  “Boring at times.”

✦ **got sidetracked** (7 comments).
  
  “Turned into general problem sharing or complaining session at times.”
  
  “Time was taken up sorting out patient stories etc.”

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**Figure 35 – The extent to which action learning sets were useful in supporting your own personal/professional development**

![Bar chart showing the extent to which action learning sets were useful in supporting personal/professional development.](image)
Workshop and action learning conclusions

Overall the representatives found these very valuable aspects of the programme. They found the opportunity to work and learn with others enjoyable, supportive and beneficial. Working with people from different organisations and from different disciplines was particularly worthwhile. The creation of a safe learning culture was valued and seen as important for the sharing of ideas, taking action and trying out different ways of doing things. They also contributed significantly to the support required by the representatives as they took up their role. This contribution came in various ways; by providing opportunities to gain support from the other representatives and the facilitator and by providing an arena in which they could develop approaches and strategies to increase, maintain or secure support from their teams and managers.

The negative comments indicate that action learning is not an approach to learning that suits everyone and that good facilitation is key to a successful outcome.

The comments about group membership, while small in number, are interesting. One manager commented on how hard it had been to be in a set with her staff team, and a team member commented on the difficulty of being in the same set as her team leader. Although only two comments were made about this issue on the evaluation forms, the membership configuration of managers and those they managed being in the same learning set occurred in a number of learning sets within the CTP. It was one of the issues that the programme facilitators discussed through their own action learning process. The conclusion was, as in the case of many of the issues raised by the CTP, there were no right or wrong answers in relation to membership configuration. It was seen to be dependent on multiple variables, including purpose, expectation, context and personality. What did appear important was the need to acknowledge explicitly the line management relationships within the set and to be alert to the influence of these on the functioning of the group and for individuals.

5.5 The team events

The CTP includes team events. These are days away from the service areas attended by as many team members as possible.

The participants, including the facilitators, evaluated each event at the end of the day. The team representatives were also asked specifically about the team events on their end of programme evaluation forms.

Data from both these sources are included in this section about the team events.

The structure of the programme included three team events for each team; at the start, the mid-point and the end of the 10-month programme. The teams and facilitators worked flexibly within this structure to provide team events that best suited the needs of the team and the organisation. For example, one programme consisted of five teams from the same intermediate care pathway. These five teams held their first team events separately, all five came together for one large event as their second event, and they worked separately again for the final events. Some teams were unable to hold full day events and instead opted for half-day events.

The purpose of the team events was broadly defined within the context of the programme as an opportunity for the teams to work on areas of team development and service improvement of most relevance to them. The results of the TPI, the patient stories and observations were intended to provide some focus and direction for the teams.

Within this broad remit the purpose, content and structure of each team event was negotiated locally between the team representatives, the teams, the managers and the facilitator. This broad approach provided a great deal of freedom for individual teams and organisations to use these events in creative ways to meet local need and priority.

The variety that this broad approach produced was enormous. Many teams used the space to feedback the TPI results and to consider what had emerged from the patient stories and observations. Many took the opportunity to invite senior managers and executive board members to the events to inform them of, and or involve them in, the work. Some invited service users and carers to join the discussions and planning.

Many newly integrated, recently moved, radically re-focused or changed teams used the events to meet and get to know and understand other team members and different team cultures. Significantly, many used the time to recognise, celebrate and sometimes mourn what had been good about the past enabling them to move on
to something new and different more easily. The programme facilitators facilitated the team events. Many worked with the team representatives, team leaders, managers or other facilitators from the RCN project team as co-facilitators on these days.

What was said about the team events

The representatives were asked to make a Likert score on the usefulness of team events; 94.3 per cent scored them as ‘useful’ or ‘very useful’ and these responses are shown in Figure 36.

Qualitative comments about team events

One hundred and ten (86 per cent) team representatives made 238 additional comments about the team events. These have been coded and categorised in the following themes:

✦ a positive and useful experience (53 comments)
  “Team members were very sceptical at first. By the final event this had changed – they were hugely beneficial.”
  “Provided an excellent forum for challenge and change.”

✦ a chance to meet everyone in a different environment (52 comments)
  “Opportunity to discuss with senior management in more informal way issues and questions around change and learning in the Trust.”

✦ they produced action (52 comments)
  “Positives from them have rippled out to whole service and continue to have benefits. These events were crucial in terms of real change towards improvement.”

✦ they brought us together as a team (30 comments)
  “It really helped break down old allegiances from the three teams that had merged.”

✦ they allowed people to be seen differently in the team (22 comments)
  “Produced highly noticeable change in team members and their relationships with others.”

✦ they helped us do some difficult things (15 comments)
  “A difficult experience at times but I don’t think the development would have happened without this.”

✦ negativity or resistance (8 comments)
  “Some staff were actively hostile and withdrew their participation this made organising team events quite worrying.”

Figure 36 – Usefulness of team events
uncertainty (8 comments).

“Not sure actions will be carried forward – difficult to keep momentum.”

Other comments related to the useful opportunity to practise facilitation skills, the difficulty of everyone attending and the importance of having the TPI results for the first event.

From the above evaluations, team events are seen to be one of the most highly-valued and useful aspects of the CTP. What appears to be valued is the opportunity for the team to meet away from the usual service environment, providing a chance for colleagues to meet and talk to people they don’t usually talk to. This allowed for the shifting of perceptions about people from different levels in the organisations, especially those in more senior and more junior roles. A focus on joint achievable action that included all team members seemed to increase ownership, provided a sense of team spirit and allowed the teams a feeling of potency and efficacy, that they can actually make a difference.

Facilitation and team events

The expertise of the programme facilitators was particularly important and valued in this aspect of the CTP. It was during the team events that the dynamics within the team both constructive and destructive were potentially available for exploration and discussion. This can be intimidating, as many of these dynamics happen at an unconscious or semi-conscious level, coming from the more primitive aspects of individuals and frequently present in ‘attack’ and ‘defence’ type interactions. Skilled facilitation is essential if individuals and teams are to be able to explore these safely and productively.

The comments in the themes of ‘doing difficult things’ and ‘negativity and resistance’ relate to this aspect of the team events and indicate the delicate balances between individual and group experience and a positive or negative outcome. This view was supported by the facilitators themselves, who found facilitating these one of the most challenging elements of the programme. They frequently worked in pairs with another facilitator from the project team and used their own action learning and team meetings to explore issues emerging from the events and to consider different approaches concerning how best to facilitate the process.

5.6 TPI evaluation

The results from the pre- and post-administration of the TPI are given in Chapter 4.

In addition to the quantitative data provided by the TPI, the team representatives were asked to rate the usefulness of the feedback and to comment on the process. Their responses are shown in Figure 37.

Qualitative comments about the TPI

As with other aspects of the programme, the representatives were asked to offer any other comments about the TPI; 108 reps (85 per cent) offered 148 comments which have been coded and categorised into the following themes:

Figure 37 – TPI feedback
THE CLINICAL TEAMS PROJECT

✦ focus for action (54 comments)

“It identified clearly areas of strength and issues to work on. It gave us comprehensive feedback.”

“It galvanised the team.”

✦ provided a way of talking to each other about the team (38 comments)

“The team is going through huge change with lots of interpersonal conflict and tension. The TPI gave us a way of talking about some of it in relative safety.”

✦ process of completing the questionnaire (29 comments)

“Team members found completing the form confusing and frustrating.”

✦ scepticism (10 comments)

“TPI confirmed how efficient and effective we are – unclear why we were told to participate.”

✦ disowned (6 comments).

“Management in the unit didn’t think it represented the unit, blamed the questions rather than resolved the issues.”

Overall the TPI was regarded as being helpful, with 70.5 per cent of representatives scoring it as ‘useful’ or ‘very useful’. It was seen as being particularly valuable as it provided concrete evidence for the teams and a focus for their development work. In many instances it seemed to spur them into action. The TPI also provided a structure within which the team could talk to each other about how they worked.

5.7 Organisational support

The representatives were asked about the extent of organisational support the CTP had received. Their responses are shown in Figure 38.

In total, 62.4 per cent of the representatives felt their organisations had supported the programme to a good or great extent, whilst 26.4 per cent experienced limited or no support.

To elaborate on their responses, 113 representatives made additional comments.

In total, 89 comments were made about helpful and positive support that was given by management. The most commonly cited level of support was the provision of time for the representatives and the teams to undertake the programme, with some commenting on the extra support received through the provision from a central budget of venues and catering for team events.

More active support was indicated by 32 comments. These were most frequently demonstrated by:

✦ attendance at team events

“Management were invited to attend the team events, and they did, the chief exec, directors and assistant directors came, which helped progress things.”

“Consultants and doctors made an effort to attend.”

“Excellent support from the director of HR and the CEO came to events.”

Figure 38 – Organisational support
spreading the learning across the organisation

“They were interested in patient stories and how they could be used elsewhere in organisation.”

“Overall good support given, commitment was there from beginning to end. They are now looking to see how the principles of the work can be used in other areas, in spite of the climate of serious pressures in the Trust, they still allowed time and support to the programme.”

asking for feedback on how it was going

“Service managers asked for and got regular feedback.”

being actively encouraging and enabling.

“Gave us positive feedback.”

“Locally management was very supportive. The team manager embraced the programme from beginning and encouraged reps to take a lead role.”

“Our team manager has been exceptionally supportive which has made the role of introducing change easier.”

In contrast, 47 comments were made indicating a lack of support. These comments were coded into the following categories:

lack of time and or funding to undertake the programme

“Disappointed better venues not provided. Other teams got venues and lunch. It makes you feel unvalued.”

“They promised to help with time and finances but didn’t happen.”

a lack of interest and involvement especially when things were difficult

“We had to fight to get the time and didn’t feel supported when trying to make changes, resolve problems. Our main support was our facilitator.”

“When problems in team were highlighted I felt isolated and unsupported – made it difficult to keep motivated.”

support was superficial or in name only

“Superficially supported but deep down little support.”

“Some managers only paid lip service.”

barriers to change coming from the managers

“Any changes suggested were quickly squashed by management.”

“Internal contacts suggested that its impact was being ‘suffered’ rather than sought to drive improvement.”

“I think our managers felt defensive – I sometimes felt like a lamb to the slaughter. I sometimes thought I’m not paid enough to do this, be in potential collision with my line managers.”

Other comments about organisational support included the high expectations that some had of the programme, the importance of having enough information before starting the programme, and one or two commented that they felt the wrong team had been ‘sent’.

Interestingly the issue of being ‘sent’ appeared very infrequently on the team representative evaluation forms. These were completed at the end of the programme. At the beginning of the programme the facilitators experienced the issue of being ‘sent’ as very much around for some of the teams and team representatives and one they had to work with quite considerably during the early weeks. The lack of comment on it at the end may be indicative either of a change in perception, it being no longer important following the experience of the programme or, possibly, that those who still felt this did not return their evaluation forms.

In conclusion, the majority of team representatives felt they were supported by their managers. In addition to ensuring staff were supported to attend the different elements of the programme, managers were experienced as being supportive when they took an interest by attending team events and asking how the programme was going. This support is important not only on a human level of showing an interest in others, but also in relation to enabling actual change and improvements to happen. Organisations made considerable investments by participating in the CTP; the benefits of this investment are increased both for the team and the organisation if managers also contribute to such investment. By this we mean support staff locally, who are trying to make changes and make the best use of their organisational roles to make links and connections to remove barriers to change, establish mechanisms to sustain the change and spread good practice.
6. What supported and what hindered the changes

To help understand some of the relationships between elements of the programme, the context and outcomes, the team representatives were asked to identify factors that supported or hindered positive change taking place.

6.1 What helped and hindered the team representatives in their role?

In relation to what had been helpful to the representatives in their role, the support of the other team representatives, both from their own teams and from other teams on the same programme, was the most frequently mentioned (55 times). The facilitator’s support, knowledge and expertise was cited by 32 people as helpful, while 25 people mentioned the support they received from the rest of their team, 18 people said that support from their line managers had helped, 22 cited the workshops and 18 the action learning as factors that supported them in their role.

In relation to what was unhelpful, taking the time away from clinical work was mentioned the most frequently (by 52 people). The next most frequently mentioned issue was the resistance of fellow teams members; this was reported variously as sabotage, jealousy, suspicion, negativity and lack of motivation by 41 people. This was linked to the difficulties they experienced in trying to get the rest of their teams involved. In addition 19 reported that all the change going on around them made their role more difficult. Lack of managerial support was mentioned by 15 people. Three representatives said they felt that their junior position in the team had not helped. Two said that being the only team representative was hard and felt like a huge responsibility.

6.2 What helped and hindered personal development

In relation to what helped and hindered personal development, 281 comments were made about what had been helpful and 63 about what was perceived as unhelpful.

The helpful aspects of the programme were grouped into six categories.

- **Specific aspects of the programme** (154 comments). Action learning was mentioned most frequently (38 times), followed by patient stories (21 times), observations (16 times) and team days (15 times). The workshops, especially power and authority, roles, diversity, leadership and communication and skills development around negotiating and influencing, were also mentioned frequently.

- **Working with others** (46 comments). Comments in this category include the benefits of working with people from different disciplines, different levels in the hierarchy and across different organisations.

- **The overall approach** (31 comments). Comments in this group included the confidential space, the time to think and reflect, and taking a positive approach to difficulties.

- **The facilitator** (21 comments).

- **Awareness of personal contribution and efficacy** (21 comments). Comments concerning an increased awareness of personal strengths, receiving personal feedback and increased understanding of impact on others were included in this category.

- **Seeing the bigger picture** (8 comments). Comments in this category mostly related to the opportunity to develop better relationships with managers that helped them see where things fitted in a wider sense.

The 63 comments about unhelpful aspects were also grouped into 6 categories.

- **Organisational and structural issues** (17 comments). These concerned the lack of direction at times, not knowing beforehand what it was about, the timing of some of the activities, and the team being too big.
6.3 What helped and hindered team development

In terms of what helped or hindered team development, 217 issues were identified as helpful and 70 as unhelpful. These were grouped into six themes.

- **Process difficulties** (15 comments). Team conflict and negativity, domination by one or two individuals and lack of communication between team representatives were included here.
- **Practicalities** (12 comments). These included getting the time to do the work, travelling for workshops and buddying for patient stories.
- **Membership issues** (7 comments). These related to attendance at activities and the membership of action learning sets, either because they were or were not in the same set as a particular person.
- **Specific aspects** (7 comments). These were comments highlighting particular exercises either in the workshops or at team events.
- **Lack of management support** (5 comments). 6.4 What helped and hindered service improvement

In terms of what helped and hindered service improvement, 179 issues were identified as being helpful. These are grouped into four categories.

- **Specific elements of the programme** (126 comments). In this category, patient stories were mentioned by 55 people, observations by 45 and team events by 13.
- **Focusing on team working** (22 comments). Comments in this group included understanding how everyone worked, everyone in the team taking part, and spending time discussing things as a team.
- **Action planning/being specific** (19 comments). These comments included the helpfulness of having action plans and specific goals to achieve.
6.5 Aspects the sponsors found helpful

In the interviews the sponsors were not specifically asked about aspects of the programme they thought were particularly helpful or unhelpful. However through the course of the discussion many mentioned specific aspects that they thought were particularly beneficial. These were as follows:

- **Patient stories** (mentioned by 23)
- **Observations** (mentioned by 22)
- **Team events** (mentioned by 17)
- **Action learning** (mentioned by 10)
- **The TPI** (mentioned by 6).

A total of 15 sponsors said that they thought the programme was well-structured.

7. CTP facilitation

The team representatives were asked to score on a five-point Likert scale, how useful they found having a facilitator; 92 per cent reported their facilitator as being ‘useful’ or ‘very useful’ with 82.4 per cent reporting the facilitator as ‘very useful’, as shown in Figure 39.

Helpful and unhelpful characteristics of the facilitators

The team representatives were also asked to identify any difficulties they had with the way that the facilitator delivered the programme and any ways in which they were helpful.

In all, 436 helpful aspects and 51 difficulties were identified. These were grouped into nine categories:

- **Supportive and empathic** (94 comments)
- **Open and accessible** (87 comments)
- **Inclusive and enabling** (76 comments)
- **Flexible and creative** (37 comments)
- **Knowledgeable** (31 comments)
- **Organised and provided structure** (28 comments)
- **Challenging** (27 comments)
- **Possessed professional integrity** (17 comments)
- **All round excellent** (39 comments).

Some of the comments made about the facilitators include:

“Enabled us to talk, gave us all a chance, all felt valued.”

“Encouraged us to look at things in different way.”

“Understanding of the pressures.”

“A normal person talking in a normal way.”

“Able to push me to the boundaries.”

“Fully engaged.”

“Inspiring.”

“Enthusiastic.”
The difficulties have been grouped into three categories.

- **Self expression/style/attitude** (21 comments). For example, three people felt the facilitator could have been more directive at times, two found them too intense, two felt they used too much jargon at the beginning, one felt they made assumptions about their team and one found them too confrontational.

- **Structure and organisation** (17 comments). For example, nine people wanted a more structured overview at the beginning. Three felt they wanted more structure in the workshops and action learning.

- **Knowledge base** (13 comments). Six people commented on the lack of local knowledge and two on a lack of IT skills.

The sponsors also commented on the facilitators. Their evaluation matched that of the team representatives. All sponsors spoke extremely highly of the facilitators. They found them credible, knowledgeable, challenging, refreshing, flexible, kind and supportive. Many commented on their expertise in handling the different dynamics in the teams, saying that they had helped them through difficult times. Many also spoke of the support and challenge they personally had received from the facilitators. They welcomed the opportunity to have someone external to the organisation to bounce ideas around with and bring in some fresh thinking. For example:

“She (the facilitator) was a star, she was very very clear, but also very friendly, straightforward, respectful but not afraid to point out various things that we needed to take on board. Very supportive to the team, but in doing so she was not overpowering or leading them along any particular route, she enabled them to be empowered.” (C2S16)

Three commented that it had taken them and the teams a while to get used to the approach of the facilitator; this was particularly around a perceived lack of structure and the challenges presented by the facilitators. Two also commented that they thought the facilitators could have been more flexible around setting dates for team events and supporting representatives to do stories and observations. One commented that their facilitator was rather disorganised which caused difficulties at times.
8. Attrition from the programme

Six teams withdrew after approximately four to five months of the 10-month programme - an attrition rate of 5.5 per cent. Five teams were in the first cohort and one in the second.

In the first cohort, an inter-agency programme between a PCT and Social Services department withdrew their two teams which left one team from a small trust who felt they could not continue on their own, so they also withdrew. The team representatives from these organisations were disappointed not to continue; they all felt they had gained a great deal personally and there was a certain sense of failure associated with them not finishing the entire programme. The facilitator and project leader spent time with the representatives to process some of these issues. Several of these representatives went on to complete the patient stories and the facilitator continued to support them through this.

One team withdrew from another programme leaving two teams which went on to complete and one team withdrew from a third programme, whilst the remaining team from that organisation completed the programme.

All the teams that withdrew had completed the workshop element of the programme, taken part in some of the action learning sets and some had undertaken team events. It is at this point in the programme that representatives and teams really have to take an active role in the programme as they begin to do patient stories and observations, plan and implement changes. It is perhaps unsurprising that it is at this point that individuals and teams struggle.

The facilitators noted it as being a difficult transition time for many of the teams as the work really did begin to have an impact on practice and required an increased time commitment to undertake the various activities. The majority of teams managed to work successfully through the challenges in this part of the programme.

Reasons for withdrawing

The programme sponsors from the three PCTs and the social service department where teams withdrew all took part in telephone interviews for the programme evaluation, and the team representatives also evaluated their experience. A face-to-face meeting was held with the sponsor from the small trust that withdrew when the other teams did. The facilitators of these programmes were also asked for their evaluation and feedback. The reasons for withdrawing were in all cases a combination of factors and no one single reason.

All sponsors talked about the lack of full understanding of what the programme entailed, the short lead in time to getting the programme going (which may have resulted in them not making the best selection of team to take part), or preparing the teams as fully as they might.

“The time frame for when the programme was introduced and perhaps some of the information we had about the programme prior to making a decision was minimal ...perhaps we needed to ask more questions. Also, we didn't have a long lead-in time so therefore the decisions we made about which teams should perhaps participate in the programme, we could've done a little bit better. Some of the teams were told of their involvement and some were asked if they wanted to be involved and that probably had an impact on their embracing of the programme.”

One of the sponsors from the inter-agency programme talked about the teams being very newly integrated and perhaps the teams being too new to take part. One of the sponsors particularly felt that the combination of a new team and a new programme had led to difficulties. The team managers of these teams reported that they had wanted to take part in the second cohort and felt this would have been much better timing, although the sponsors had wanted them to join the first cohort.

One sponsor wondered whether being new in post had also contributed:

“I hadn't been here very long then either. I think I'd been here a couple of months actually, that's probably part of it. Perhaps people signed up and agreed because they thought this is the new director come in and we'd better.”

The time commitment required by the programme, combined with sickness and staff changes, also played a significant part in the decisions to withdraw.
In the programme where the health and social service organisation withdrew their teams, no steering group meeting between senior managers and the programme facilitator took place, despite efforts to establish such a meeting. These were the only organisations where no such meetings happened and all concerned think that this was influential in the teams not being able to complete the whole programme.

Two of the sponsors thought that the programme was insufficiently flexible to accommodate their local circumstances; this was particularly the case around the practicalities of undertaking the patient stories and observations. One sponsor felt that the facilitator had not offered sufficient direction when the teams were struggling.

The sponsor from the small trust talked about the difficulty of being dependent on other organisations to take part. This is an important issue to consider in future programmes.

For one of these teams the facilitator felt that it was the line manager of the team that wanted them to withdraw and not the team or the representatives. In this case the team was disappointed not to continue, as they felt they were making good progress – a perception that was shared by the facilitator.

The team that withdrew from the second cohort was one of a number of teams taking part from different parts of the hospital, with the intention that they all work together within an integrated care pathway. Whilst complicated and difficult to unpick, it was felt by both the facilitator and the manager of this team that their withdrawal was motivated by political issues relating to ownership around different aspects of the client pathway.

It was pleasing to note that the low attrition rate was even less for the second cohort, with only one team not finishing the whole programme. This is attributed to the increased experience of the facilitators. They were more able the second time around to notice early warning signs of teams struggling and intervened sooner. They were alerted to the challenging transition time around the end of the workshops and supported the teams through this process. They were also more confident about the programme and more able to work flexibly with the structure to meet local variation, without compromising the integrity of the programme.

In the second cohort, one or two teams that were put forward to take part were ‘counselling out’ by the facilitators before they began. With their learning from the first cohort, the facilitators saw early signs that a team would really struggle following discussion with those involved and encouraged these not to take part. These early signs included extreme difficulty the facilitators had in arranging times to meet with potential representatives, their team leaders or managers, meetings repeatedly being cancelled at the last minute and the inability of teams to find anyone who could consistently take on the role of team representative. In these circumstances it was seen as a more ethical decision to view this as not the right time or programme for them, rather than embark on a process that was likely to be unsuccessful.
9. Discussion

This part of the report is presented in three sections. The first section provides a discussion of issues relating to the CTP as an intervention to enhance team development. The second section explores aspects of service provision, where participation in the CTP or a similar programme has something to offer teams and organisations in the current policy climate. The third and final section offers a critique of the evaluation.

9.1 The CTP as an intervention

The CTP had three broad objectives:
- to increase team effectiveness and team functioning
- to improve client care and service delivery
- to contribute to organisations meeting strategic objectives relevant to the wider modernisation agenda.

The findings presented in the earlier sections of this report suggest that taking part in the CTP did increase team effectiveness and team functioning, that improvements to client care and service delivery have taken place, and contributions were generated to individual organisational objectives.

Taking the realistic evaluation question 'What works for whom and in what circumstances' (Pawson and Tilley, 1997) this section will explore some of the factors that influenced the extent to which the CTP was successful in achieving its aims.

The following paragraphs identify some of the factors that appear from the evaluation data to be influential in relation to the CTP and its processes and outcomes.

9.1.1 Team size

The research evidence suggests that the optimum team size is between 8 and 15 members (Borrill and West, 2002). The difficulty that participants on the programme encountered around identifying who was in their team was evident. This difficulty was characterised by a desire for inclusion, as teams become multidisciplinary, integrated and work across agencies. Such inclusion has resulted in teams with very large membership. Intermediate care, stroke and discharge teams are being established with the imperative that individuals see themselves as one team. This imperative appears to come from team members and those involved in more senior service development positions. These very large teams are overwhelming, both in their numbers and the geographical spread of office location and service delivery. In these cases it is extremely difficult to apply the research evidence for effective team working, for example shared clarity of purpose, clarity of roles, regular meetings, participation of all team members in team processes and decision-making. Individuals become demoralised at the enormity of the task.

The results from the pre- and post-administration of the TPI in this project indicate that the teams in the second cohort made more progress in their team development than those in the first. Apart from the facilitators' increased familiarity with the CTP, the only other factor that appears to differentiate the teams in cohort 1 from those on cohort 2 is team size, with cohort 2 having smaller team sizes. This finding supports the research evidence that smaller teams are more effective.

In the CTP only 26 per cent of teams reported a membership of between 8 and 15; however those with a larger membership did make improvements. Many teams that took part looked at different ways of configuring and conceptualising their teams to allow for multidisciplinary and partnership working and to incorporate systems and processes for effective team working. Conceptualisations that were useful included:
- having a core team that would at different times include associate members
- having several sister teams that may all perform the same tasks and have the same systems and protocols but have smaller membership numbers, for example having three teams on an inpatient unit
- having different teams performing different functions within an overarching network.

Establishing clear purpose and objectives, understanding the different roles and expertise of team members and having some permeability in relation to the team boundary so that individuals can join different teams and communication can happen between teams...
when necessary, were all important in enabling teams to think creatively and differently about their team configuration.

From a psychodynamic perspective Obholzer (1994) argued that whilst different positions, in this case including everyone in the team, may on the surface appear to be a democratic way forward, they may also be part of a defensive process. For example, including everyone means that potentially difficult decisions about who is the most appropriate, who has the particular expertise required, whose development need is greater and so forth, together with the need for trust if someone else is to represent you, are avoided.

Including everyone can also be a means of ensuring that nothing happens or maintaining the status quo. How often are decisions not taken or delayed because a particular person or group is not present? In recognition of the absolute importance of inclusion in team working, it is important to encourage questioning about inclusion; who needs to be included and why? Is it part of a defensive process? How can we ensure that everyone who needs to be included really is included?

In conclusion, the findings from this evaluation support existing evidence that teams with a smaller membership are more effective. Although teams with membership over 15 can make improvements to their team effectiveness, it is more challenging. We would recommend that where team membership is reported as very large, time is spent considering different ways to configure or conceptualise the teams to enable them to apply the principles of good team working to their systems and processes.

9.1.2 Support – where does it come from and what does it look like?

The need for support to undertake any development programme or implement any change is frequently reported. How much is needed, what it looks and feels like and who provides it is much more complicated.

The findings from this evaluation indicate that the team representatives found taking part in the CTP both challenging and rewarding. The extent to which the representatives experienced the challenges as something they were able to work with to achieve positive results or as something that outweighed any benefits, was influenced by multiple factors. To gain some understanding of what made the difference, the representatives were asked to identify what helped and hindered them in their role.

In relation to what was helpful, support was the most frequently mentioned factor. The support came from four sources:

✦ from the other team representatives, both within their own team and from the other teams on the same programme
✦ from the facilitator
✦ from the rest of the team
✦ from the managers.

In relation to what was unhelpful three factors were most frequently mentioned:

✦ the time release from clinical work
✦ resistance from their fellow team members – this was reported variously as sabotage, jealousy, suspicion, negativity and lack of motivation
✦ lack of managerial support.

Thus having the time and not being in it alone are seen as crucial if the challenges intrinsic to examining team working and implementing change are to be worked with constructively.

Ideally, one would like support from all four sources listed above and when this is the case, positive changes in team functioning and service improvement are more likely. For many of the representatives, however, this support was not available in equal measure from all four sources consistently throughout the programme and yet positive changes in team functioning and service provision did take place in these teams.

Support from the other team representatives and the facilitator were only mentioned as helpful factors. Support or lack of it from managers and teams were identified as both helpful and unhelpful factors respectively. In fact both of these potential sources of support were mentioned more frequently as lacking and therefore unhelpful. Lack of support from the team was more frequently identified than lack of support from the managers. This is interesting, as many individuals and teams are quick to blame ‘them’ (i.e. others often unnamed but external to the team) for difficulties or
barriers to making the changes they would like. This evaluation indicates that the difficulties may more frequently stem from ‘us’ rather than ‘them’.

The extent to which support from these sources can be created, controlled or predicted by those responsible for designing and delivering team development programmes is questionable. Indeed for many teams, difficulties within the team (so that support was unlikely to be forthcoming) may be a reason to undertake team development in the first place. Equally, teams that apparently have helpful and constructive team processes may at times operate in ways that are destructive and unhelpful, especially when asked to change or examine how they are working.

So whilst there may be little control over the team dynamic, any team development programme should include structures and processes that are likely to maximise the support available for people leading the change and influenced by it. This is especially important when individuals are trying to influence change within their own teams and thus opening themselves up to some potentially difficult and painful processes.

9.1.3 Organisational support

In relation to organisational support, the establishment of a steering group for the CTP in each organisation was intended to provide both support for the programme and a means by which learning and good practice could be spread and sustained throughout the organisation. Several organisations chose to agenda the work and progress of the CTP into an existing meeting, rather than set up a separate group.

The only programme where there were no meetings with senior management about the practicalities and progress of the CTP was in the two organisations that withdrew before completion. These two organisations chose to agenda the work and progress of the CTP into an existing meeting, rather than set up a separate group.

The team representatives also offered insights into what it was that they actually found supportive from their managers. In addition to being released to attend the different elements of the programme, these were:

✦ taking time themselves to attend some of the programme activities
✦ using their position to spread information about the work
✦ asking how it was going
✦ offering positive encouragement and feedback.

Most of these require little additional time commitment on the part of the managers; they relate to what Cardona (2003) terms psychological presence – a capability she considers to be crucial for successful management in today’s constantly changing NHS. Certainly the team representatives appreciated such actions, finding them to be helpful and supportive.

9.1.4 Teams experiencing change

A contextual factor that one intuitively might think would influence the outcome of the programme is the extent to which teams were involved in other changes during the time of the CTP. Not surprisingly, the majority of teams taking part in the CTP reported being in the midst of and/or anticipating major changes. Apart from one rather extreme situation of a...
community hospital closing almost overnight, with no apparent warning for staff or patients, the presence of change by itself did not prevent participation in the programme or the teams achieving positive outcomes, although several of the team representatives commented that the amount of change they and the team were going through did not help them in their role.

The majority of sponsors talked about the programme supporting the teams, and to some extent organisations, through a period of change and transition. Several also mentioned that it had helped and supported them to do their jobs through times of significant change.

Two teams reported that the programme had come at the wrong time for them because health and social care teams had just integrated and it was ‘too early’; however there were more examples of it coming at exactly the right time because health and social care had just integrated. The main difference between these comments about timing appeared to be how the individuals involved perceived the CTP. Those who saw it as coming too soon saw it as something additional to do; a luxury that might be nice if they had the time, but currently felt more like a burden. Those who felt it came at just the right time saw it as a source of support to help them do what they had to do anyway.

There is an important message here for all those trying to engage overworked and overwhelmed staff in development work; it needs to support and enable the work and not be something they have to do in addition to everything else.

9.1.6 The team representatives

We worked with 252 team representatives through the CTP. Just under half were nurses and just over half were in positions that you might automatically associate with leadership. From the data we have, there is no evidence to suggest that coming from a particular discipline, or holding a particular role within the team, was associated with a more positive experience for the individual or more positive outcomes for the team.

In relation to position in the hierarchy, authority and power were important issues. Obholzer (1994) identified authority as coming from above – more senior colleagues and managers, below – more junior colleagues and peers, and within – one’s own sense of self-esteem and confidence. Roberts (1998) talks about power from four sources: personal power from one’s own knowledge and personality, instrumental power from what one owns or has control over, projected power which is attributed to you by others, and official power stemming from your role or title.

In both of these frameworks, power and authority are seen as relational concepts, that is, they cannot all be possessed by individuals alone or by any one individual but are dependent on a relationship with others for their effective enactment. Because of this relational quality, the actual role or position of the individual team representative is not what is important; rather it is important how that individual can best mobilise all available sources of authority and power. Where individuals did not possess or have access to particular sources themselves, it was important that they could access others who could make them available.

This is why support from management and the rest of their team colleagues as discussed in the previous section, was so important. Support is needed in order to access and mobilise all possible sources of power and
authority (as outlined in Section 9.1.2).

A health care assistant (HCA) team representative spoke about these issues in the following comment:

“As an HCA it was difficult to get management to understand and recognise that I was a team rep, also being young it was difficult to get things across without feeling that I was above my station. On the other hand, being an HCA was useful as it helped me get other HCAs interested and involved.”

Thus whilst being an HCA presented challenges in terms of accessing official and instrumental power and authority from above, it was important in relation to securing authority from below. Another example of being able to engage a whole group or discipline through the representation of that discipline on the programme is provided in one of the sponsor evaluations:

“Getting a general surgeon involved and acting as a champion has certainly enabled us to get clinical buy in from the medics to some of the strategic issues of the trust.”

Once they had started the programme, several teams saw the importance of the involvement of someone in a specific role or from a particular discipline, and sought to either involve them as a team representative or to secure their involvement through team events, the steering groups or other mechanisms.

So whilst the particular role or discipline is not important the following issues in relation to selection of team representatives were important:

✦ having more than one team representative
✦ having representatives from different disciplines
✦ having representatives from different levels in the hierarchy.

One of the issues to emerge for the programme facilitators throughout the project was the role of the team leader or team manager, if they were not a team representative. The crucial importance of actively engaging and involving them with the programme was quickly apparent. Not to do so left them isolated and potentially threatened by the work that was going on. It also made it extremely difficult for them to take up their role effectively as team leader or manager with the team; the facilitators had to work consciously not to undermine their position.

Whoever the representatives were, providing means by which they can access and mobilise power and authority from all available sources is important for the success of the programme. The qualities identified in Figure 22 (Section 5.1) were influential in helping the representatives take up their role. These include the ability to:

✦ hold service users as central to service provision
✦ take a flexible approach
✦ demonstrate empathy and respect for others
✦ be open to change
✦ motivate others
✦ negotiate and challenge effectively
✦ articulate ideas clearly.

9.1.7 The role of the facilitators

The programme facilitators played a pivotal role in the CTP. They were extremely highly valued by the team representatives, the teams and the sponsors. Specifically they were:

✦ neutral – not allied with any particular group
✦ inclusive of all
✦ skilled in working with group dynamics
✦ flexible and creative
✦ knowledgeable
✦ organised and provided structure
✦ challenging.

They did a lot more than facilitate the workshops, learning sets and team events. They worked organisationally in a variety of ways. They worked with steering group members as well as sponsors and they frequently had individual meetings with different stakeholders. These were often with team leaders or managers who were not team representatives.

These organisational elements of the work of the facilitator were crucial in positioning the programme within the structures of the organisation and not allowing it to sit in an isolated unconnected capsule.

The neutrality and external position of the facilitator was helpful in that it allowed managers and leaders who
might normally take a facilitation role to be part of
events, and they were not perceived as coming with any
personal or organisational agenda.

As this evaluation has repeatedly shown, one of the
challenges thrown up by team development and change
are the complex intra and interpersonal processes
exposed and examined by such activity. This requires
expert facilitation. Working with the dynamics present
in a team of people who worked together before any
team event or workshop and have to work together
again afterwards, requires a higher level of competence
than facilitating a group of students on an education
programme or an action learning set where members
do not see each other outside of the set. The facilitators
found the team events to be the most demanding and
challenging elements of the programme to facilitate for
this reason.

The facilitators were themselves part of a team that met
regularly for team meetings, action learning and 1:1
management support. They also frequently contacted
each other via telephone and email and often worked
together as co-facilitators. These situations provided
opportunities for support, challenge, thinking,
exchange of ideas, receiving feedback, and developing
skills, knowledge and understanding of team working
and team development and social time together. The
facilitators reported that these aspects of team working
were vitally important in enabling them to carry out
their roles effectively.

In summary, the role of the facilitator significantly
influenced the outcomes of the programme. Important
factors were:

✦ they had time
✦ they worked organisationally as well as facilitating
  the different elements of the programme
✦ they were neutral
✦ they were skilled at working with process
✦ they were members of a team.

9.2 The different elements of
the programme

It is important to view the CTP as a whole programme
comprising of several inter-related elements. In this
evaluation we have gathered data about the different
programme elements and which elements were
particularly helpful in achieving particular outcomes.
This provides useful information for those wanting to
invest in development programmes, as it allows
commissioners to make informed decisions about
which elements to incorporate in programmes designed
with different intentions in mind.

9.2.1 What worked

When looking at outcomes, we asked what factors
contributed to or hindered positive changes for
individual development, team development and service
improvement.

In relation to individual development, working with
other people from different disciplines, teams,
organisations and levels in the hierarchy was seen as
most helpful. Action learning was highly valued and the
acquisition of new knowledge and skills through the
different workshops was also evaluated very positively.
The whole approach of the programme in creating a
confidential space in which people were able to reflect
and think, and where a positive approach to difficulties
was taken, was also seen as important.

In relation to team development, team events were seen
as the most useful element of the programme. The
different roles associated with the programme,
including the team representative role, the facilitator
and the role of the manager, were seen as very helpful.
Taking an action-orientated approach, focusing on real
issues was very positively evaluated, as was paying
attention to team dynamics. Structures and processes
designed to involve all team members which frequently
involved a culture shift was also seen as important.

Patient stories and observations were evaluated as the
most useful elements in relation to service
improvements. Focusing on developing team working,
with an emphasis on action planning around real issues
were identified as very useful, as was having time to
reflect, think and plan.
9.2.2 What were the challenges?

Through all the different methods of gathering evaluation data, we always explicitly asked respondents to identify challenges or difficulties associated with taking part in the CTP. Overall the identified benefits far outnumber the identified difficulties.

Whilst there was some differentiation in relation to which elements were helpful for personal, team and service development, the factors that presented challenges to the process were the same, whatever the particular focus for development. These included:

- time release from clinical work
- working with team processes
- getting the whole team involved
- practical issues about programme structure and delivery.

**Time release from clinical work**

This is likely to remain an ongoing tension for the CTP and any other education and development work. A balance always needs to be achieved between investment and outcome, looking to the short, medium and long term.

The time investment required for the CTP is considerable and was identified as a challenge by the majority of team representatives and their sponsor managers. For the majority that took part, this investment was worthwhile in terms of outcome for services, individuals, teams and organisations. In terms of the 10-month duration of the programme, only one sponsor said that they thought it was too long. The rest thought it was the right length. They considered that a reasonable length of time is required really to get to grips with some of the underlying issues around collaborative working and to provide support whilst some of the changes are implemented.

**Working with team processes**

Meeting the aims of the CTP involves bringing about change in teams. Evidence from change management literature shows that introducing change is not a straightforward process (Senge, 1999; Obholzer, 1994; Roberts, 1998). Similarly, evidence from the team working literature shows that working collaboratively with others is not always easy (Onyett, 2003; Payne, 2000). Individuals bring their own agendas – conscious and unconscious – to both the change and the team process. People have different energies, capacities, motivations and priorities that will at different times strive to move things forward and at other times strive to maintain the status quo; some will want to move in one direction and others in another direction at different times and in different ways.

The CTP works with both teams and change. It was to be expected, and was indeed the case that the dynamics described above were evident throughout the process. They were enacted through the workshops with team representatives, through team events, between steering groups and programme participants, between organisations and the programme. Whilst some found these processes difficult and did not want to engage with this difficulty, others viewed them, with their sometimes associated conflict, as constructive and healthy. They provided opportunities to explore differences, understand others, have their different voices heard and to move forward in constructive ways.

The evidence presented in this report demonstrates that the CTP does indeed support people in bringing about change and working more effectively in teams. However it should be acknowledged that the work is difficult and challenging and is likely to produce feelings and experiences that are not always viewed as positive by all concerned. The role of the facilitator and their capability and capacity to contain the process, that is to manage the emotional response of those involved in the work, is seen as crucial. This process of containment is central to providing sufficient space, both physical and psychological, for participants to be able to work effectively with the material offered within the programme.

**Getting the whole team involved**

The CTP is a team programme and it is important that the whole team commits to the programme. The team needs to be involved in the team events, completing the TPI, taking patient stories and doing observations. They also need to be involved in identifying and taking action forward from these activities. As reported throughout
this evaluation, some of the team representatives struggled to engage the rest of their team. This increased their sense of personal responsibility and added to their experience of feeling overwhelmed.

**Practical issues about the programme structure and delivery**

Several of the sponsors and team representatives said they would have liked more information about the programme before it began. They wanted more detail about the time commitment, how the programme worked, what the role of the team representative was, how the rest of the team got involved and the role of the steering group.

A few commented on the need to set dates for events well ahead of time, to avoid school holidays and to stick to dates once set.

There were one or two comments about the programme needing more structure. However such comments were far outnumbered by positive comments about the flexibility of the programme, and the fact that the programme achieved the right balance between structured input and information and space for reflection and discussion.

**Recommendations for future programmes**

The following strategies that take account of the comments made in the evaluation will be implemented for future programmes:

- more detailed information provided prior to starting the programme
- the programme facilitator will meet the team and team representatives prior to the first workshop and team event
- the first team event will take place earlier in the programme
- the TPI will be administered earlier in the programme
- team members other than team representatives will be invited to join workshops on patient stories and observations
- the emphasis on personal development will be increased through the early workshops with the intention of increasing the team representatives’ sense of personal authority to take the programme forward in their teams
- the nine workshops and learning sets will be reduced to six each, and the workshops delivered over a slightly longer period of time. This will reduce the intensity and amount of information received at the beginning of the programme and enable team representatives more time to process the material and take things back to their team. It also reduces the time release required
- action learning will be introduced earlier – before the workshops have been completed. Action learning provides the opportunity for the team representatives to critically reflect on the implementation of the programme with their teams and to receive challenge and support in this process from their colleagues in the set. This will provide more support for them earlier in the process, as they engage their teams with the programme.

**9.3 Developing teams to improve service provision**

It is not the purpose of this report to give a comprehensive review of the literature concerning team working and its potential benefits for health and social care provision. This is provided very effectively elsewhere (see for example, West (2004)).

The relationship between team functioning and patient outcome is complex and methodologically challenging to quantify and examine (McPherson et al., 2001). Research undertaken by Borrill and West (2003) demonstrates that where more staff members work in real teams, patient mortality is lower at an organisational level. Other studies have also linked improved interprofessional collaboration with improved patient outcome. For example a critique of research into cardiac rehabilitation (Brennan, 1997) shows that interprofessional collaboration results in improved levels of functioning following bypass surgery. Similarly, studies exploring functional improvement in orthopaedic conditions indicate greater gains where interprofessional collaboration is effective (Munin et al., 1998; Di Fabio, 1995) and Bower et al. (2003) found
relationships between team process, structure and outcome and the quality of diabetes care.

Whilst it remains challenging to draw direct correlations between patient outcome and team effectiveness, evidence concerning the relationship between effective team working and other aspects of improved health and social care provision is evident. The findings from the CTP support this evidence and also show the ways in which a contribution to improved service provision can be made through developing effective teams.

This section of the discussion will explore four aspects of service provision:

✦ pathways of care or care networks
✦ getting the most from available expertise
✦ patient safety
✦ innovation, spread and sustainability of change.

These particular areas have been chosen because improvements brought about through participating in the CTP suggest that it has something to offer organisations wanting to make changes in these areas. They are of relevance in the current policy climate and there already exists a body of knowledge about the aspect of provision and team working.

### 9.3.1 Pathways of care

The white paper *Our health, our care, our say: a new direction for community services* (DH, 2006) continues the NHS modernisation theme of placing the service user at the centre of service provision. It builds on the papers *Creating a patient led NHS: Delivering the NH improvement plan* (DH, 2005b) and *Commissioning a patient led NHS* (DH, 2005a). A key message in these papers is that consumers of health and social care services should be able to access services of the highest quality at times and in locations best suited to them. Issues of choice, quality, access, efficacy and efficiency will take precedence over who provides the service.

The ability to work across agencies and collaboratively within and across disciplines is crucial if coherent pathways that avoid duplication and provide access to the highest quality, most effective and efficient services are to be developed. Many services are looking at service delivery through networks as a means to address these issues.

Several studies examining the influence of team working on client pathways indicate that more effective team working does provide more streamlined, cost-effective and higher quality services. However, these studies also come with caveats that in order to be most effective; the structures and processes of integrated pathways must be supported organisationally. Appropriate education and development programmes are required to support individuals and teams in the new ways of working, for example Edwards (2004), Pethybridge (2004), Burbach et al. (2002), Masterson (2002), Ross et al. (2000).

Many of the teams taking part in the CTP made improvements to client pathways and improved their clinical networks as the themes identified in the service improvement section of this report indicate. This was achieved through:

✦ listening to and involving service users and their families
✦ improving collaborative working within and across teams largely around shared objective setting, and procedure and protocol development
✦ making changes at transition points of assessment, admission, referral and discharge
✦ increasing access to the knowledge and expertise of different disciplines
✦ changing ways of working to include critical review and feedback on performance, and focused reflection on the work.

### 9.3.2 Getting the most from available expertise

The need to make the most effective and cost-efficient use of resources is high on the government's agenda and consequently that of every health and social care provider. This agenda can be supported by reducing duplication of service provision and ensuring that the expertise of the different health and social care workers is used in the timeliest and most appropriate ways to provide the best services for users. In the world of service networks across agencies, multiple providers and patient choice, it is imperative that members of
health and social care teams understand and appreciate the contribution that their role and the roles of colleagues make to service provision. Such an understanding is identified through Borrill and West’s (2002) research as characteristic of effective team working.

Threats to professional roles and cultural differences between disciplines and agencies are frequently cited as barriers to effective team working (Peck and Norman, 1999; Manthorpe and Iliffe, 2003). This has sometimes resulted in a call to ‘blur the boundaries’ between professions. Rushmer (2005) argued that in fact it is the opposite that is required and that clarification of boundaries is a prerequisite for safe and effective collaborative working. In making this assertion, Rushmer refers specifically to issues of accountability, potential abdication of responsibility and increased levels of anxiety and stress that occur when boundaries are blurred. Others support this view – for example Rafferty et al. (2001) found that nurses with higher levels of professional autonomy also scored more highly in team working. Nancarrow (2004), in a study of role boundaries in intermediate care teams, concluded that confidence in one’s own role and understanding of the roles of other workers was important in reducing the perceived threat of others. She also suggested that this confidence and reduced threat enabled people to work flexibly and accommodate necessary role overlap in pursuit of the best service provision.

The findings from this evaluation of the CTP support the views described above. Increased clarity of one’s own role and that of others was one of the most frequently cited changes at an individual and team level. This was associated with increased confidence, decreased conflict and, importantly, reduced duplication and increased access to a range of services for service users. Case study 3 earlier in this report provides a good illustration of this.

Evidence from this evaluation indicates that increased understanding and valuing of one’s own and others’ roles also contributes to increased morale, motivation and reduced negative conflict. All of which are associated with lower staff turnover and reduced sickness and absence rates, which in turn impact on quality and cost of service.

9.3.3 Safety

Safety is an issue of critical importance to both consumers and providers of health and social care services. The reasons for this fall within two broad areas. Firstly, the human, moral and ethical stance that contact with health and social care services should enhance or maintain physical, psychological and spiritual wellbeing and not detract from or jeopardise it. Such a stance is legally enshrined through the duty of care within the professional codes of conduct. Secondly, circumstances where safety has been compromised have huge financial costs for the health service in terms of litigation.

The relationships between team working and safety have been explored within the literature (Mearns et al., 2001; Kayes, 2004; Stein, 2004). Fraher (2005) argued that leadership training for teams should include an examination of authority issues and illuminate covert and overt group processes and warns that a failure to do so can result in flawed decision-making with potentially fatal consequences.

In recent years the health service has been drawing increasingly on team development work undertaken in the aviation industry particularly in relation to reducing errors (Helmriech et al., 1999). Firth Cozens (2001) looks at the issue of learning from incidents and takes this away from the sole responsibility of individuals, placing it firmly in the arena of team working and organisational culture. Specifically she focuses on the fact that a safe environment for patients (and staff) is one where questioning, reflection, review, feedback and reporting are allowed and encouraged; in other words where there is not a blame culture but rather a culture of appropriately holding to account and being accountable. When individuals are working in interdisciplinary teams, within networks and pathways and across agencies, these issues of open communication and mutual accountability are both crucially important as the Bristol inquiry (Kennedy, 2001) and the inquiry into the death of Victoria Climbié (Laming, 2003) tell us, and particularly challenging. It is important because failure to achieve this really does have fatal consequences and challenging because all the old chestnuts of power, status, hierarchy, inclusion, exclusion and professional loyalty swing into action.
In the CTP the most frequently reported change in team functioning was an increase in open dialogue and critical reflection. This included an increase in challenging and questioning practice in ‘professional’ rather than ‘blaming’ ways, an increase in honest and direct communication between disciplines and between different levels in the hierarchy, and a willingness to listen to others and actually hear what they had to say.

In this way the teams in the CTP were developing characteristics of teams more likely to prevent and report errors.

Another theme to emerge in relation to the changes in teams was the increased participation of everyone in the team, often relating to the increased involvement of junior and non-professional members of the team in influencing and decision-making. These team members frequently have the most contact with service users and are at the front line of service delivery. This directly addresses the issues raised by Fraher (2005) of enabling people to speak out regardless of differences in role or hierarchy.

A final comment on safety relates to the role of the service user. Edwards (2002) explores the concept of the service user as an honorary member of the health care team. She identifies that “their key strengths within the team would be:

✦ their unique perspective on the effectiveness of care
✦ being continuously in touch with monitoring progress; and
✦ being available to take action instantly.”

So service users potentially have a key contribution to make in ensuring safety. The largest number of service improvements reported by teams in the CTP was grouped in the category increased client-centred provision. These improvements involved creating more opportunities to talk and listen to service users and their families, and improving the quality of information, based on what service users said they needed and wanted to know. Initiatives such as these are likely to enable service users to take up the role of honorary team member, as described by Edwards (2002), and contribute to the provision of safe quality care.

In conclusion, developing teams through the CTP is likely to increase patient safety as the teams communicate in more open, direct ways across hierarchy and discipline. In addition questioning, reflection and feedback are more common and more team members and service users are involved and have the opportunity to speak and be heard.

9.3.4 Innovation, spread and sustainability

These are issues that have challenged initially the Modernisation Agency and now the NHS Institute for Innovation and Improvement, as the Labour government seeks to improve and modernise the NHS. In order to keep pace, provide the best quality of care and survive in the turbulent world of health and social care, individuals, teams and organisations need the ability to innovate and to share and embed new learning into current practice, all of this whilst remaining alert and open to further developments and change. This requires a level of capacity, capability and resilience way beyond the scope of any one individual. Again team working becomes essential.

The most frequently reported change by the sponsors at a team level was an altered relationship to change. They reported the teams being more proactive, having more ownership of change and being more in touch with their own ability to influence and shape change. The service improvements implemented through the programme provide further evidence of the teams’ ability to innovate.

It has not been within the scope of this evaluation to undertake a longitudinal approach to establish the extent to which any of the reported changes have been sustained over time. However, in a review of the literature on sustaining organisational change Buchanan (2003) identifies 11 sets of issues that contribute to conditions likely to support sustainable change in organisations. These are:

✦ substance
✦ process
✦ temporality
✦ contextual
✦ organisational
✦ cultural
✦ political
Through the CTP, aspects highlighted in many of these sets of issues have been developed and are evidenced in this report. For example, in relation to substance the changes must be seen to fit with the overall strategic direction of the organisation. Process issues include the involvement of change champions with high levels of communication and involvement. In cultural issues, the need for shared norms and goals, a belief that change is possible and an encouragement of team working is emphasised. The political issues encompass the need to involve all staff and stakeholders in decision-making, individuals take a proactive stance, are confident and welcome innovation. Managerial issues include the need to confront difficult issues and adopt an open facilitative style, whilst leadership provides vision, clarity of purpose, is consistent and challenging and committed to change.

Whilst the sustainability of the changes has not been assessed, many of the conditions likely to support sustainable change have been developed through participation in the CTP.

9.4 Limitations of this evaluation

In the evaluation of this project every effort has been made to ensure validity and reliability of data and analysis and interpretation of these data. Views have been sought from different stakeholders and a previously validated team effectiveness tool was used in the TPI. The different methods and processes used to gather data for the evaluation were presented, scrutinised and revised by the RCN Research and Development Committee and the whole project received ethics approval from the Thames Valley MREC.

Despite this, the evaluation does have limitations. Firstly, it has been conducted internally by the project team responsible for designing and delivering the programme; no external evaluation was commissioned. This raises the question of potential bias of the evaluators. All respondents have been explicitly asked throughout for negative and critical comment and the methods of data collection were designed to enable individuals to offer this type of feedback as much as possible. This feedback is fully reported in this evaluation.

The use of the TPI as a development, as well as evaluative, tool, together with the short time interval between administrations brings into question the validity of the findings. These decisions were taken, as the primary purpose of the commissioned project was to provide team development and not to undertake a research study. Any interpretation of the results has been made with this in mind.

The links made between participation in the CTP and service improvement rely heavily on reported changes and existing research evidence that links team effectiveness to service improvement. The number of teams involved, together with the enormous number of influencing variables and the scope and primary purpose of the overall project, all militated against an evaluation design that incorporated more specific and predetermined outcome measures.

As a future development, although service users views are very much part of the process of the programme, we would want to include within the evaluation methodology a way of incorporating service users views on evaluating increased team effectiveness.
10. Conclusion and recommendations

Through taking part in the CTP, teams did increase their effectiveness and team functioning. These teams made improvements to client care and service delivery and this did contribute to the strategic objectives of organisations taking part.

Key factors in the teams achieving positive outcomes were:

✦ team size
✦ the extent to which the team representatives could access authority and power from within themselves, their colleagues and their seniors
✦ the presence and expertise of the facilitator.

Positive changes took place for the team representatives, their teams and in the services they provided for clients.

For the team representatives the changes included:

✦ gaining of new knowledge and skills
✦ the ability to work better with others
✦ a greater sense of own power and ability to influence change
✦ a changed approach to change
✦ improved leadership capabilities
✦ the ability to see the bigger picture.

For their teams the changes included:

✦ more open dialogue and critical reflection
✦ more effectively working with conflict
✦ increased understanding and sense of team
✦ more proactive – action-oriented
✦ increased morale and motivation
✦ increased involvement of everyone in the team
✦ increased clarity of individual roles and contribution
✦ improved relationship between teams and agencies
✦ changes to team processes and structures
✦ increased leadership
✦ increased awareness of the bigger picture.

And for clients and services the following improvements were identified:

✦ more client-centred provision
✦ more integration within teams and across services
✦ improvements to the way teams organise service delivery
✦ taking a different approach to team working
✦ increased access to a range of services
✦ improvements to the client pathway
✦ improvements to the environment of care
✦ improved meal times.

The following local and national policy initiatives were supported through participation in the CTP:

✦ Patient and Public Involvement
✦ National service frameworks
✦ Valuing People
✦ Clinical governance
✦ The Essence of Care
✦ Improving Working Lives
✦ Standards for Better Health
✦ Integration of health and social care
✦ Leadership and management strategies
✦ Development of services in the community
✦ Long term conditions strategies
✦ Organisational development strategies
✦ Service development for stroke services
✦ Introduction of meaningful performance indicators owned by staff
✦ Admission avoidance
✦ Shared governance
✦ Development of a group of people to drive the whole modernisation agenda.
What helped?

The CTP should be seen as a whole programme, however the evaluation identified that different elements were particularly useful in supporting different aspects of change. For personal development, the opportunity to work with people from different teams, different disciplines, and different organisations and from different levels within the hierarchy, in a learning culture that fostered critical thinking, reflection and support was seen as invaluable. The process of action learning brought these elements together and was highly valued as an approach.

In relation to achieving changes within teams, the increased knowledge gained about how teams work and the introduction of tools and techniques for translating the theory of effective team working into practice helped the team representatives get the rest of their team involved in team development.

The team events facilitated by an experienced neutral facilitator, together with an action-oriented approach was important, as was paying attention to team dynamics and processes.

Using patient stories and observations again coupled with an action-oriented approach, with the provision of space in which to reflect, think and plan, helped implement improvements in client care and service delivery.

The major challenges to participating in the programme were:

✦ the investment required in terms of releasing staff from clinical work
✦ working with the dynamics in the teams that either pre-existed the programme and/or were raised in response to exploring collaborative working and implementing change.

The changes achieved through participating in the CTP indicate that the teams have developed some of the necessary capabilities to work effectively with current service provision challenges, including:

✦ the provision of integrated care pathways
✦ getting the most from available expertise
✦ patient safety
✦ innovation, spread and sustainability.

This has been an exciting, challenging, sometimes frustrating and difficult yet fundamentally rewarding project as we worked with the different dynamics, enthusiasms, hopes, setbacks and celebrations of the teams. The learning from this experience has provided us with unique and privileged insights into teams and their ways of working as they strive to improve their ability to work together to provide better care and services for those who use them.

Conclusions and recommendations

✦ Creating time and space for people in the same team, from different disciplines and different levels of the hierarchy to talk to each other and think about what they do, how they do it and how they could do it better, is essential in enhancing team effectiveness and improving services.
✦ An action-orientated approach that necessitates working together on real tasks is central to developing effective teams.
✦ Where team membership is reported as large (over 15), time should be spent considering different ways to configure or conceptualise the teams to enable them to apply the principles of good team working to their systems and processes.
✦ Individuals and teams involved in implementing change need access to the necessary power and authority from within themselves, their colleagues and their seniors in order to bring about change. Personal development, active support from managers and the provision of external support systems are required to enable individuals to effectively access this necessary power and authority.
✦ Facilitators that are experienced and skilled in working with group processes, and are perceived as neutral, are necessary for the exploration of inter- and intra-team dynamics.
✦ Programmes such as the CTP involve implementing change and exploring team dynamics; neither is straightforward or easy. Those commissioning, participating in and facilitating such programmes should be aware of and anticipate this and provide the necessary support mechanisms to help people through the challenges.
Time is required to allow some of the complex processes involved in change and collaborative working to be thought about, experienced, challenged, owned and implemented. Ten months was seen as a good length of time to enable some of this to happen.
References


Obholzer A (1994) Authority, power and leadership: contributions from group relations training, in Obholzer A and Roberts V (editors) *The unconscious at work: individual and organisational stress in the human services*, London: Routledge.


Appendix 1

Management of the Clinical Teams Project

The project team

<table>
<thead>
<tr>
<th>Role</th>
<th>Names</th>
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</thead>
<tbody>
<tr>
<td>Project lead</td>
<td>Anne Benson</td>
</tr>
<tr>
<td>Programme facilitators</td>
<td>Yaakov Atik</td>
</tr>
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<td></td>
<td>Gerald Conyngham</td>
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<tr>
<td></td>
<td>Mandy Cox</td>
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<td></td>
<td>Judith Francois</td>
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<td></td>
<td>Alison Hayes</td>
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<td></td>
<td>Dave Lees</td>
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<tr>
<td></td>
<td>Joy Nash</td>
</tr>
<tr>
<td></td>
<td>Sue Nash (replaced Jennifer Pearson)</td>
</tr>
<tr>
<td></td>
<td>Jennifer Pearson (left team in November 2004)</td>
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<tr>
<td></td>
<td>Matthew Rice</td>
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<tr>
<td></td>
<td>Maria Richardson</td>
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<td></td>
<td>Paul Vaughan</td>
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<td></td>
<td>Susan Whitby</td>
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<td></td>
<td>Ewan Wilkinson</td>
</tr>
<tr>
<td></td>
<td>Phyllis Woolford</td>
</tr>
<tr>
<td>Project administrator</td>
<td>Jazz Seahra</td>
</tr>
<tr>
<td>Business support</td>
<td>Janet Donnelly</td>
</tr>
<tr>
<td>Support securing MREC approval</td>
<td>Gill Harvey</td>
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</tbody>
</table>

Financial management

The CTP was funded by the NHS Leadership Centre. This funding covered the salary and travel costs of the project team, the provision of programme materials and the supporting infrastructure of the project within the RCN, including the governance structures, the production and dissemination of this report and the production of team effectiveness guides based on the evaluation of the project.

Financial reports were provided at the quarterly project steering group meetings.

Participating organisations covered the costs of any local administrative support, staff attending the programme and programme venues.

Project governance

A steering group provided operational guidance and direction for development, delivery and evaluation of the CTP. The group formed part of the formal accountability structure between the NHS Leadership Centre as commissioners of the project and the Clinical Leadership Team RCNI as developers and deliverers of the project.

An advisory group of external advisors was established to engage in critical discussion with the project team concerning the content, quality, direction and delivery of the CTP. The advisory group reported to the steering group.

Membership of the advisory group is given below.
### CTP advisory group members

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title and organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Benson</td>
<td>CTP Project Lead, RCN</td>
</tr>
<tr>
<td>Geraldine Cunningham</td>
<td>Acting Head, RCNI</td>
</tr>
<tr>
<td>Janet Donnelly</td>
<td>CL Team Business Manager, RCN, HQ</td>
</tr>
<tr>
<td>Lindsey Hayes</td>
<td>Senior Fellow Leadership Primary Care, RCN, HQ</td>
</tr>
<tr>
<td>Karen Webb</td>
<td>Regional Director, RCN, Eastern Region</td>
</tr>
<tr>
<td>John Badham</td>
<td>Head of Nursing for NPfIT, Clinical Governance Support Team, Modernisation Agency</td>
</tr>
<tr>
<td>Elaine Whitby</td>
<td>CTAG Team, Greater Manchester</td>
</tr>
<tr>
<td>Dr Carol Borrill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Executive Director of Aston Centre for Health Service Organisation Research</td>
</tr>
<tr>
<td></td>
<td>- Senior Lecturer in work and organisational psychology, based at Aston University, Birmingham</td>
</tr>
<tr>
<td>John Badham</td>
<td>Director of The Essence of Care, Modernisation Agency</td>
</tr>
<tr>
<td>Ros Boddington</td>
<td>Associate Director, NHS Clinical Governance Support Team, Team Resource Management Programme</td>
</tr>
<tr>
<td>Hilary Lance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Non-Executive Director, Camden and Islington Mental Health and Social Care Trust</td>
</tr>
<tr>
<td></td>
<td>- Independent Management Consultant/Trainer in the field of health and social care management, focusing on personal and team effectiveness</td>
</tr>
<tr>
<td></td>
<td>- Tutor on the <em>Managing in health and social care postgraduate programme</em> delivered by Harrow Business School at the University of Westminster, and Module Lead for personal and team effectiveness</td>
</tr>
<tr>
<td>Robert Johnstone</td>
<td>Trustee of LMCA (Long Term Medical Conditions Alliance)</td>
</tr>
<tr>
<td>John Shanks</td>
<td>Learning Programmes Manager, Management and Leadership, NHSU</td>
</tr>
<tr>
<td>Anne–Toni Rodgers</td>
<td>Director, Government Affairs and Public Policy - Europe Baxter Healthcare Ltd, Baxter World Trade SA</td>
</tr>
<tr>
<td>Keith Wilshere</td>
<td>Assistant Director, AHPs and Governance, Clinical Governance Team, Kingsway Hospital</td>
</tr>
<tr>
<td>Diane Spalding</td>
<td>Director of Nutrition and Dietetics Services, Hinckley and Bosworth PCT</td>
</tr>
<tr>
<td>Kay Matthews</td>
<td>Assistant Director of Primary Care Development, Redbridge PCT</td>
</tr>
<tr>
<td>Dr Sophie Staniszewska</td>
<td>Senior Research Fellow, Research Team, RCNI</td>
</tr>
<tr>
<td>Kate Ireland</td>
<td>Director of Service Improvement, East Yorkshire PCT</td>
</tr>
<tr>
<td>Jane Nicklin</td>
<td>Allied Health Professionals Programme Lead, Essex WDC – previously on steering group and added to the advisory group at evaluation</td>
</tr>
</tbody>
</table>
Appendix 2

Organisations taking part in the Clinical Teams Project

**Cohort 1 (spring)**
- 5 Boroughs Partnership NHS Trust
- Bath and North East Somerset PCT
- Bedfordshire Heartland PCT
- Bedfordshire Social Services
- Chesterfield PCT
- Chesterfield and North Derbyshire Royal Hospital Trust
- Chesterfield Royal NHS Trust
- Chorley and South Ribble PCT
- Hampshire Ambulance Service NHS Trust
- Lancashire Social Services
- NHS Direct
- North Devon PCT
- North Devon Social Services
- North East Derbyshire PCT
- Northampton PCT
- Norwich Learning Difficulties Service
- Norwich PCT
- Reading PCT
- Richmond and Twickenham PCT
- Rotherham General Hospitals NHS Trust
- Southampton City Council Social Services
- Southampton City PCT
- St Helens and Knowsley NHS Hospital Trust
- Thurrock PCT

**Cohort 2 (autumn)**
- Broadland PCT
- Cambridgeshire Social Services
- Central Manchester PCT
- Dudley Group of Hospitals NHS Trust
- East Cambs and Fenland PCT
- East Lincolnshire PCT
- George Elliot NHS Trust
- Halton PCT
- Ipswich Hospital NHS Trust
- Isle of Wight NHS Trust
- Lincolnshire Social Services
- Luton Borough Council
- Luton PCT
- Luton and Dunstable Hospital Acute Trust
- Norfolk Social Services
- North Warwickshire PCT
- Portsmouth City PCT
- Sedgfield PCT
- South Leeds PCT
- South Manchester PCT
- South Warwickshire General Hospital NHS Trust
- South Warwickshire PCT
- Staffordshire Moorlands PCT
- Suffolk Coastal PCT
- Teignbridge PCT
- United Lincolnshire Hospitals Trust
- Manchester Children’s University Hospitals NHS Trust
- Manchester Social Services
- Nuffield Orthopaedic Centre NHS Trust
- Whipps Cross University Teaching Hospital
- Wokingham PCT
Appendix 3

Team representative evaluation form questions

1. The workshops
How many workshops did you attend?
The extent to which they were useful in the following areas (recorded on 5-point Likert scale):
✦ for your own personal/professional development
✦ to support you in your role as team representative
✦ to provide ideas for taking the work back to your team
✦ as a space for dialogue and sharing ideas.
Any other comments about the workshops?

2. Action learning
How many action learning sets did you attend?
The extent to which action learning was useful in the following areas (recorded on 5-point Likert scale):
✦ for your own personal/professional development
✦ to support you in your role as team representative
✦ to help in the development of action plans for your team
✦ to help in the implementation of action plans.
Any other comments about action learning?

3. The TPI (Team Performance Inventory)
How useful did you find the TPI feedback for your team (recorded on 5-point Likert scale)?
Please make some comments to expand on the answer you have chosen.

4. Team events
How many team events did your team have?
How many were you able to attend?
How useful did you find the team events (recorded on 5-point Likert scale)?
Please make some comments to expand on the answer you have chosen.

5. Your role as team representative
In your role as team representative were you able to:
✦ undertake patient stories?
✦ undertake observations?
✦ get other members of your team involved?
✦ develop action plans?
✦ implement action plans?
What factors:
✦ helped you in your role?
✦ made it difficult to fulfil the role?
Any other comments about the role of team representative?

6. Your employing organisation
To what extent do you think your organisation supported your team in the programme (recorded on 5-point Likert scale)?
Please make some comments to expand on the answer you have chosen.

7. Impact of the programme
Do you think the programme has contributed to your personal/professional development? (Recorded on 5-point Likert scale.)
Please list any areas in which you think you have developed personally or professionally.
Please comment on aspects of the programme you found unhelpful and helpful in relation to your personal development.
Do you think the programme has contributed to any positive changes or developments in your team? (Recorded on 5-point Likert scale.)
Please list any areas in which you think your team has developed.

Please comment on aspects of the programme you found unhelpful and helpful in relation to your team's development.

Do you think the programme has contributed to any improvements in service delivery or client care? (Recorded on 5-point Likert scale.)

Please list any improvements in service delivery or client care.

Please comment on aspects of the programme you found unhelpful and helpful in relation to making improvements to service delivery or client care.

How useful did you find having a facilitator? (Recorded on 5-point Likert scale.)

Please comment on any difficulties you experienced with the way your facilitator delivered the programme.

Please comment on any ways in which your facilitator was helpful in the way they delivered the programme.

8. Team folder

How useful was the clinical teams folder you were given at the beginning of the programme? (Recorded on 5-point Likert scale.)

Please comment on anything that you think could be usefully included or taken out of the folder.

10. Any other comments you wish to make about the Clinical Teams Programme?

11. What is your professional discipline/background?

Thank you for taking the time to complete this form.