

IMPROVING TEAM WORKING

A Guidance Document



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

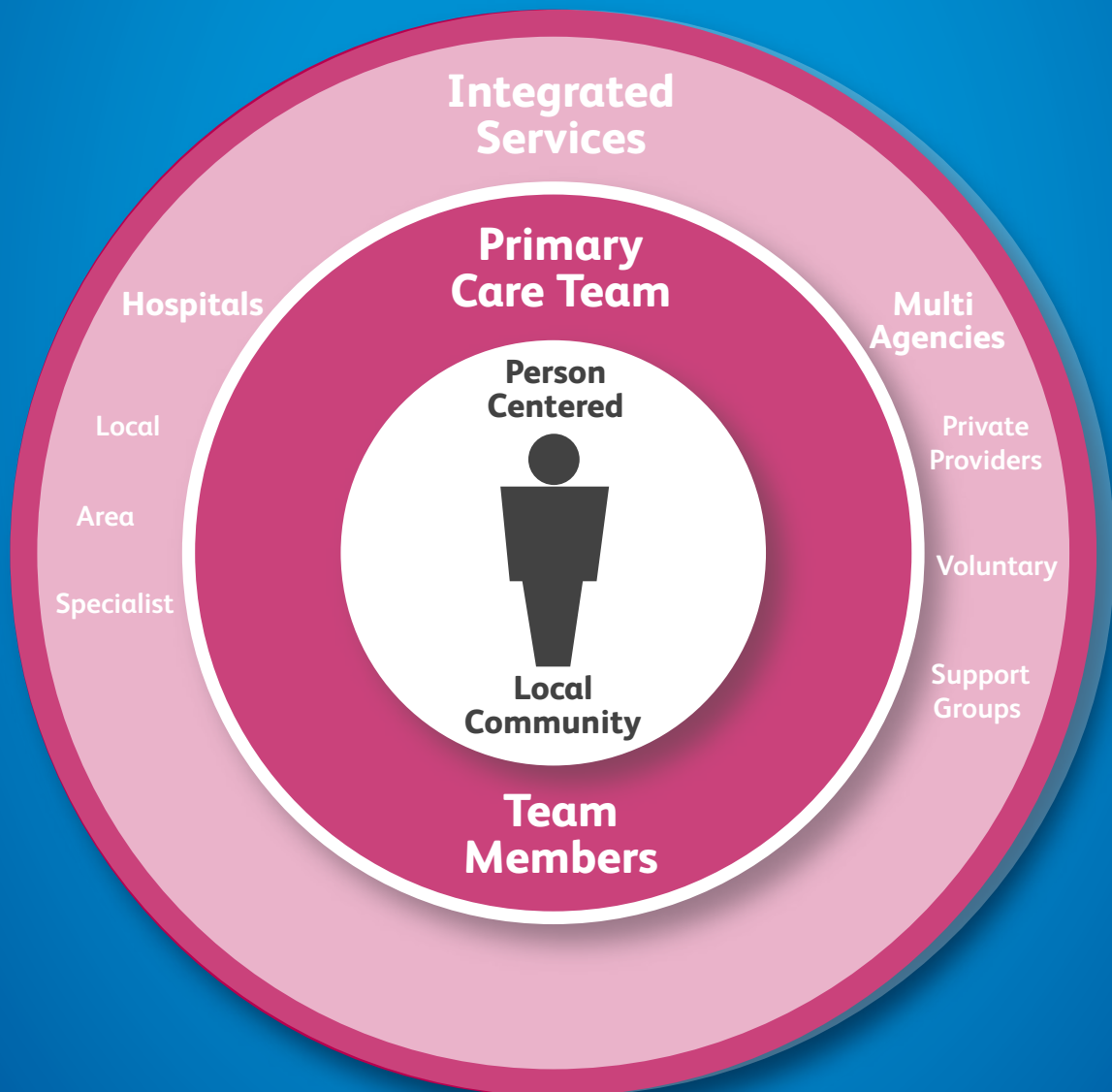
Development of this Guidance Document

This Guidance Document - *Improving Team Working* - is part of the the ongoing commitment by the HSE Organisational Change Function within Human Resources to develop resource materials to build capacity to manage change and promote service improvement. It has been developed by Caitríona Heslin and Anne Ryan based on applied work in the Dublin North East region.

April 2010

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Primary Care Model

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Introduction

This Guidance Document to support team development within primary care services has been developed based on our experience of working with teams and groups across Dublin North East. We have therefore taken an applied and practical approach to assist the process of team development. This Guidance Document builds on the work previously completed in relation to promoting a consistent approach to managing change in the health and social care services¹. It is in line with a standardised national approach to Primary Care Team (PCT) development and recognises the need for flexibility in local implementation. This Guidance Document is not intended to be the definitive guide to team working; rather it is aimed at providing guidance to those who will be facilitating teams in their establishment and enabling them to function effectively.

In line with national guidance we are proposing that teams are provided with the support required to work through three critical phases - the **Preparation Phase**, the **Early Development Phase** and as teams progress - the delivery of specific **Team Development Modules**.

It is acknowledged that oversight for primary care service and team development resides with local managers in line with national guidance. In this regard, the Heads of Discipline/Services have been critical in driving a multi-disciplinary team based approach to the reconfiguration and ongoing development of primary care services. This work has been guided by Local Implementation Groups and in some instances by locally based Project Groups which have taken a lead in progressing developments working alongside the Transformation Development Officers (TDOs). Throughout this Guidance Document we make reference to these overarching Clinical Governance/Steering Groups. Based on our experiences to date these groups have been invaluable in providing collective leadership and oversight.

Purpose of this Guidance Document

- The purpose of this document is to build internal capacity and to act as a resource to development staff, Heads of Discipline, local resource persons and others who will be working with teams to assist and guide early team development
- It provides core contextual knowledge that will assist people in being more prepared to lead and guide discussion, and it also provides practical assistance at each stage of the team development process

The planned outcome is that PCTs are enabled to perform productively and effectively in delivering the highest possible levels of care to their local communities. It is important that teams have:

- A clear purpose and robust processes to enable them to work effectively both clinically and from a business perspective
- Clarified roles, responsibilities and communication channels
- A clear action plan, agreed decision-making processes, and systems for monitoring and measuring their performance

1 See *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive* (2008).

Development Process

This Guidance Document continues to be a work in progress, and will be reviewed and updated based on feedback from those who use it. It will also need to be updated based on progress in relation to the Integrated Services Programme and other national developments. The development process for this document was informed by:

- Development work in relation to primary care service developments and team working with Heads of Discipline/Services, primary care staff and managers in Dublin North East
- It was also informed by Organisation Development and Design (OD&D) colleagues
- The TDOs Dublin North East provided oversight in relation to the overall development and guided the process
- Practical assistance was also provided by members of the Performance and Development (P&D) Team, Dublin North East and the Children and Family Services Training Team, Dublin North East

Key resource documents included:

- The Primary Care Strategy: *Primary Care: A New Direction* (2001a)
- The National Framework: *Team Development for Health Service Executive (HSE) PCTs – Proposal* (June 2007)
- The Framework for PCTs – *Internal Working Document - Version 2* (11/6/09)
- Primary, Community and Continuing Care (PCCC): *Framework document to align care group services – Interim Report – Progress and Action Plan 2008*
- *Vision Document for PCTs: Vision of Primary Care – Version 1.0* (1st July 2008)
- Dublin North East Implementation Plan: *Supporting Team Development for PCTs HSE Dublin North East* (19th June 2007)
- *Delivery of development supports in Dublin North East - Team Development for PCTs: 'Supporting local delivery'* (8th January 2008)
- West, M.A. and Markiewicz, L. (2003). *Building Team-Based Working: A Practical Guide to Organizational Transformation (One Stop Training)*. USA: Wiley-Blackwell Publishing

Throughout this document there is significant reference to *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive* (2008). Further information on accessing this document is available on: <http://hsenet.hse.ie> and www.hse.ie. Additional resources are also available on: www.hseland.ie. Copies of *Improving our Services* and *Improving Team Working* can be obtained from: Organisation Development and Design, HSE Dublin North East, Dublin Road, Kells, Co. Meath or e-mail: tara.orourke@hse.ie or telephone: 046-9280533.

We would also welcome feedback on this Guidance Document to assist us to improve our practice and the resource materials available to the system. Feedback can be forwarded to us through the contact details noted above.

Using this Guidance Document

This document is presented in two parts:

PART 1: Contextual background needed to engage in the development of primary care services

PART 2: Approach to team development – practical guidance

It is important to acknowledge that team development interventions need to be aligned to stages of readiness within teams. Therefore, what is advocated in the use of this Guidance Document is a flexible approach that is not necessarily linear and which encourages a Facilitator to adapt to the current and emerging needs of teams.

In many instances locally based resource staff will be working alongside their Heads of Discipline, the locally based TDO, staff from P&D, OD&D, Partnership Facilitators and others. A collaborative approach is advocated that builds on the range of skills available at local and area level. Therefore, throughout the document there are direct references for people who will be taking up a facilitation role and our references to a Facilitator are intended to encompass all of the above people.

Part One

Contextual background
needed to engage in
the development of
primary care services

PART 1:

Contextual background needed to engage in the development of primary care services

1.1 Integrated Services Programme

1.2 Primary Care Teams and Networks

1.3 Model of Primary Care Team and Network

1.4 Eligibility and Accessibility

1.5 Local Health Office Context

INTRODUCTION AND CONTEXT

As a Facilitator it is important that you are familiar with key contextual knowledge in relation to primary care service developments at national, area and local levels. All of these developments are taking place within the context of the HSE's commitment to implement an integrated health and social care model for Ireland. In this regard, it is important that you are familiar with developments with regard to the Integrated Services Programme and the establishment of Integrated Services Areas.

The following overview will assist you in building the knowledge required to assist in team development and sign post you to other sources of information.

1.1 INTEGRATED SERVICES PROGRAMME

At national level the two national service delivery 'pillars' (the National Hospital's Office and the PCCC Directorate) have been integrated under a single Directorate for Integrated Services. The objective is to consolidate the existing eight Hospital Networks and four PCCC Areas into four regional operating units. The organisation's service planning capabilities have been integrated into the Corporate Planning and Control Directorate. Responsibility for development and rollout of service frameworks and assurance in respect of clinical standards and risk has been assigned to the Quality and Clinical Care Directorate.

Within Dublin North East, a Regional Director of Operations (RDO) with responsibility for all the health and social care services in this region has been appointed. Part of his responsibility will be to work closely with the National Care Group leads for Children and Families, Disability, Mental Health and Older Persons Services. The RDO will also work closely with the Clinical Director/s of Quality and Clinical Care. The full implementation of the structural changes associated with the implementation of the Integrated Services Areas is still under development.

1.2 PRIMARY CARE TEAMS AND NETWORKS

Vision and Purpose of Primary Care Teams

Primary care is the first point of contact people have with the health and personal social services. The Primary Care Strategy: *Primary Care: A New Direction* (Department of Health and Children (DOHC), 2001a) set out a direction for primary care as the central focus for the delivery of health and personal social services in Ireland. The Integrated Services Programme is also committed to ensuring that service users will be able to access a broad spectrum of health and social services through their local PCT and Network, and to configure PCTs so that they deliver optimal and cost effective results.

Primary care is the appropriate setting to meet 90 – 95 percent of all health and personal social service needs. It is an approach to care that includes a range of services designed to keep people well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services provide first-level contact that is fully accessible and have a strong emphasis on working with communities and individuals to improve their health and social well-being.

The aim of a PCT is to provide primary care services that are accessible, of high quality and meet the needs of the local population. PCTs will provide an integrated pathway for clients across all HSE services, close to clients' homes.

A PCT is a multi-disciplinary group of health and social care professionals who manage and deliver health services to a defined population (the recommended average is 8,000 people managed by each team), at 'primary' or first point of contact with the health service. PCTs will be established based upon a balanced social and medical care model.

Principles

The key principles underpinning the vision for primary care services are noted below.

Principles underpinning the delivery of Primary Care Services

The principles outlined below were developed across a range of services within Dublin North East and are continually used to guide our practice.

- Whole population approach that is responsive to the changing needs of families and the local community, and which is based on assessed needs for a defined population
- Co-ordinated multi-disciplinary team/service response with the PCT acting as the main hub of service delivery
- Teams will develop shared care arrangements as appropriate with other services both within the HSE and the voluntary and community sector in order to support a co-ordinated approach along the client pathway
- A holistic approach that maintains a client/family/community focus over the whole lifecycle – promoting an appropriate and balanced medical and social care model of service delivery

- Services located in the local community with a focus on continuity of care and easy access
- A service that is accessible and responsive to locally assessed need and is grounded in local community knowledge
- Emphasis to be placed on health promotion/early intervention and prevention
- A service that makes the most effective use of all resources and facilitates resource allocation based on client need
- A service that is delivered through PCTs and Networks, and that actively develops linkages with the acute hospital sector, other teams and services and wider community groups and agencies

Overall objectives for Primary Care Service Development

Clarity regarding the objectives for primary care service development will assist staff and service users in being clear about the expected outcomes to be achieved. The objectives outlined below were developed across a range of services within Dublin North East and reflect the overall national and area level vision and direction for the development of primary care services. They reflect the principles for primary care services outlined above.

1. To provide the overarching leadership to progress the development of primary care services within the context of the broader integration agenda including care group/specialist services and the acute hospital sector.
2. To create and agree a shared direction for primary care services within the context of integrated service delivery across PCCC and the acute sector, and develop an associated implementation and communication plan.
3. To ensure a multi-disciplinary team response to enable families and individual clients to receive a joined up response to meet their needs in their Network areas.
4. To use relevant information on the population needs of the target area including demographics, health and social care status to inform decision-making.
5. To outline and describe the client pathway from initial need identification, intervention and appropriate outcome within an integrated model of service delivery.
6. To promote a culture of team working as the preferred way of delivering services and support teams through appropriate interventions.
7. To specifically address the interface between local community and PCT services, other Network services, the acute hospital sector, and other voluntary and community based services.
8. To attend to the key enablers for effective team working and service delivery with a particular focus on infrastructure and ICT.
9. To ensure the most effective and efficient use of all the resources available.
10. To monitor, evaluate and review progress on implementing the targets set nationally and locally with a focus on service improvement and increased efficiencies and effectiveness.

1.3 MODEL OF A PRIMARY CARE TEAM AND NETWORK

Moving to a Primary Care Model of Delivery

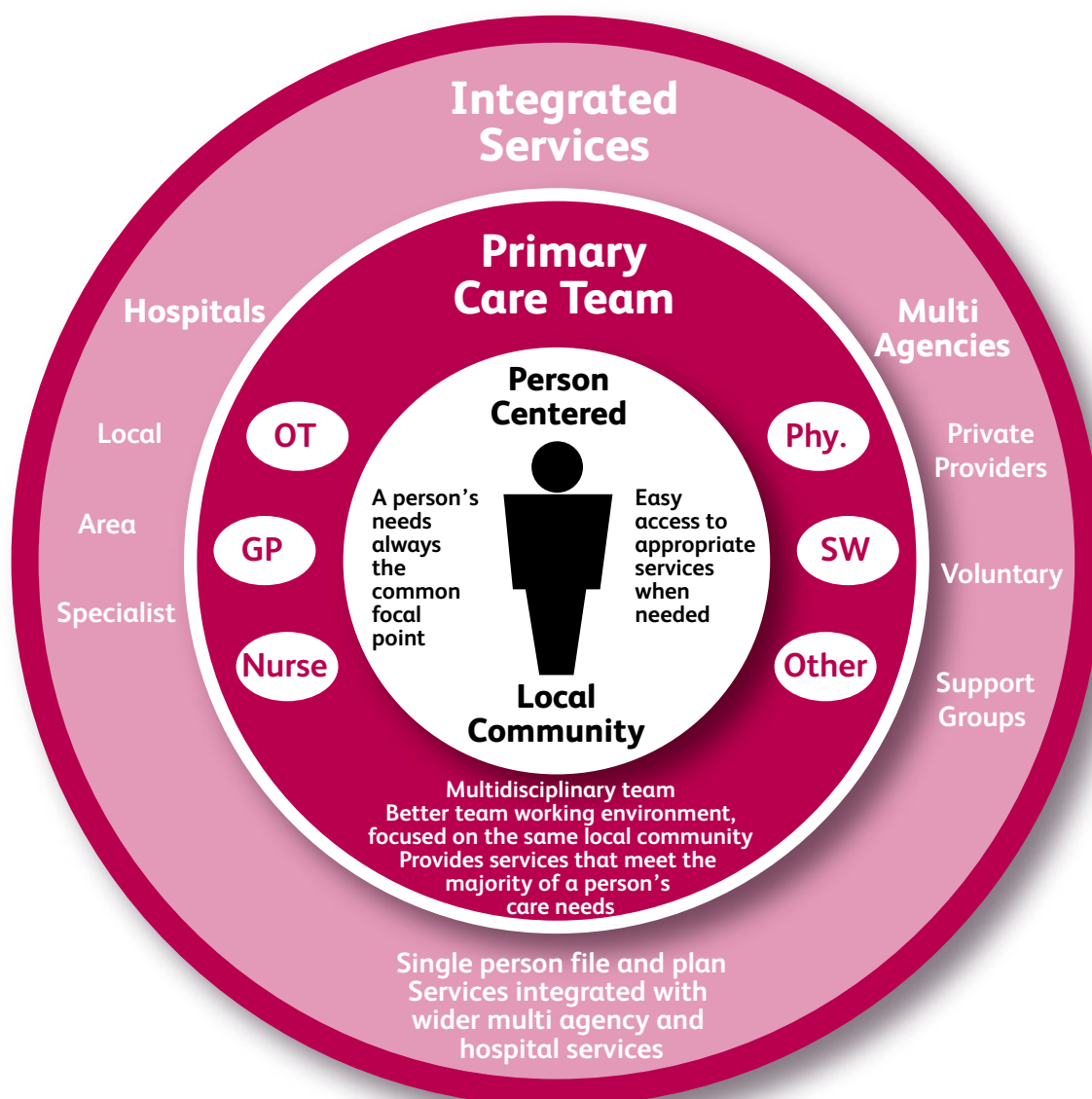
PCTs are making a difference, not just in treating illness, but also in supporting people to care for themselves and their families, improving wellness, preventing illness and supporting those with long-term problems, from a health and social well-being perspective.

As primary and community care services are further developed more care will be provided locally and the focus of PCTs will extend beyond treatment and support services to include a more comprehensive disease prevention and health promotion approach. These services will include approaches directed towards improving and maintaining the health of the population, as well as first-line services to restore people's health when they are unwell. This requires a collaborative and multi-disciplinary approach between health and social care services and teams both within the statutory, voluntary and community sector.

This approach requires a significant cultural shift both within the broader population, with potential clients/service users and staff. This reorientation is dependent upon active engagement with local communities in order to raise awareness of the potential of primary care services to meet the majority of health and social care needs.

- It is intended that most of the primary and social care needs are met by locally based PCTs – the members of the PCT will be aligned to locally assessed needs and resources
- Teams have common goals based on healthcare outcomes and shared values. They also have shared standards and operating processes
- An average of five PCTs will make up a Health and Social Care Network (HSCN) serving a wider, but related population of 30,000 to 50,000 people
- HSCNs will include a pool of specialised resources that serve PCT communities
- PCTs and HSCNs will be integrated with hospitals, multi-agencies, private providers, voluntary agencies, and with support groups

Figure 1 below outlines the core elements of the primary care model with the client at the centre and the PCT acting as the first point of contact for clients/families within their local community. The membership of the PCT in this figure is for illustration purposes only.



Note: Phy = Physiotherapist SW = Social Worker

Figure 1: Core elements of the Primary Care Model

Source: Vision of Primary Care - Version 1.0 Dated 01/07/2008

What are Primary Care Teams?

To facilitate the development of PCTs the appropriate HSE staff are being reconfigured into PCTs and Networks. There has also been a focus on securing additional resources and developments are occurring on a phased basis. In some areas the resources needed to establish PCTs are available; in other cases primary care services have been established on a Network basis pending further development to complete the plans for the recommended number of teams in each area.

Population health approach and local access

1. A PCT provides a first point of contact for clients to the health services and constitutes a focal point to both provide and co-ordinate the vast majority of general health services to clients.

2. The population to be served by a PCT is determined by geographical boundaries and/or the practice population of participating general practitioners (GPs). It is estimated by the HSE that each PCT will provide services to a population of approximately 8,000 to 10,000 and the wider Network will provide services to populations of approximately 30,000 to 50,000. The services provided by PCTs will be determined by local population needs and will need to adapt to changing needs of the population over time.
3. PCTs are providing patients/clients with greater access to services by improving the availability of current services through:
 - the provision of health professionals based on the health needs of their local population
 - the deployment of services currently hospital based within the local community
 - prompt referrals to appropriate services and decreased waiting times
 - improved access to diagnostic services over time
 - increasing public awareness through posters, community newspapers and notice boards

Governance of PCTs

1. Each Local Health Manager (LHM) is responsible for establishing a Local Implementation Group (LIG) which will be the vehicle for the development of PCTs and HSCNs in his/her area. The objective of the LIG is to promote the vision of the PCTs and HSCNs in each area with a broad representation of key stakeholders including GPs, HSE staff and the community/voluntary sector.
2. The governance and management arrangements for PCTs and Networks are currently under consideration at national level and as a Facilitator you need to be informed of any developments in this regard. Issues being addressed include responsibility for service planning, service development, service quality, resource management, budget management and overall clinical governance. The importance of an appropriate and integrated business and clinical governance framework that supports multi-disciplinary team working can not be overstated. All primary care service and team developments should take place within this context. The design and oversight of development should be an inherent role of an overarching multi-disciplinary governance group.
3. To support the work of the LIGs, Project Groups have been formed in some areas. These groups have provided leadership regarding the ongoing development of primary care services. Having identified the need for clinical/business governance for day-to-day operational issues some of these groups have formed into Clinical Governance/Steering Groups as an interim measure pending the outcome of national discussions. The existence of these groups has been helpful in progressing a unified and multi-disciplinary approach to primary care developments. These groups are also attending to the key readiness factors that will assist any revised governance arrangements.
4. Experience to date has indicated that these overarching Clinical Governance/Steering Groups in consultation with staff within PCTs have in line with national and local guidelines developed standard operating procedures, care protocols and are attending to quality, safety and risk frameworks and disease based programmes of care underpinned by National and International evidence-based practice.

Management and organisation of teams

1. It is proposed that each PCT develops a high level of self-sufficiency and becomes a self-managed team within the context of the overarching governance arrangements in each area. Self-managed includes the ability to:
 - organise its own clinical activity through regular case management and review processes for cases requiring multi-disciplinary intervention by the team, or referral to specialist services
 - organise team leadership and chairing roles appropriate to good case management and efficient team working
 - establish effective working relationships with other PCTs in its Network, with specialist services and with service partners
 - establish appropriate administrative support internally and agree additional functional support at Network level
2. Ideally all members of a PCT will be based in the same building, where accommodation is appropriate and available to enhance multi-disciplinary work.
3. Team members will engage in team development and team planning on an ongoing basis to support collaborative working.

Team approach

1. The needs of the client will be assessed through a **multi-disciplinary** approach, where appropriate.
2. All of the team's health and social care professionals will work together when appropriate to develop individualised **care plans** for patients, particularly those with chronic illnesses and other complex needs. They will share information and their respective skills to ensure that patients with the greatest need receive services in a timely and co-ordinated way.
3. **Clinical meetings** will be held regularly and attended by members of the primary care multi-disciplinary team, where appropriate, in order to provide an integrated approach to care delivery. National guidance in relation to clinical meetings has been adapted to meet local requirements in a flexible manner in some areas. (See locally developed **Standard Operating Procedures²**).
4. Services provided by care groups/specialist teams and non-statutory agencies, including voluntary bodies (commissioned by the HSE) will be aligned to PCTs and HSCNs.
5. Patients or clients with a complex array of needs will have a named **Key Worker** usually from within their PCT. The Key Worker is the person nominated by the team who co-ordinates the delivery of the patient's/client's individual care and treatment plan, and links with Key Workers in other services as required, for example disability services, mental health services. This concept ensures that the services are planned and delivered in a structured manner and the patient has an advocate and often single point of contact. The Key Worker concept is naturally evolving within teams and is based on consensus within the team regarding the co-ordination of client needs. Selecting the Key Worker therefore will be based on a team assessment of the most appropriate person to take on this role based on a number of factors such as level of interaction with the client/family, relationship

2 Standard Operating Procedures (SOPs): some areas have adapted national guidance to meet local requirements and developed Standard Operating Procedures.

with the client/family and/or knowledge/skill base. It is important to note that every client/patient will not require a Key Worker. The team overall will track the number of clients assigned to any team member in order to balance the workload and responsibility within the team.

Who are the members of Primary Care Teams?

The make up of teams will be a local issue, determined by local need and priorities of its defined local population. Core team members within a Dublin North East context may include Public Health Nurses and Community Registered General Nurses, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Psychologists, Social Workers, Administrative staff, GPs, Practice Nurse. In some areas the team may include Community Mental Health Nurses, Family Support Staff, Healthcare Assistants, Home Helps, etc.

The current position is that job descriptions for members of PCTs have been agreed nationally. Members of PCTs will continue to report to their clinical Head of Discipline with a particular focus on clinical governance. However, it is important to acknowledge that the core working relationships will be with PCT members and service/clinical decisions will be made in line with client needs and within a team context. However, the overarching Clinical Governance/Steering Group will have a role in providing leadership and guidance to ensure consistency and a multi-disciplinary response to addressing the clinical governance agenda.

What is a Health and Social Care Network?

PCTs are linked together by HSCNs. PCTs will have working relationships with other PCTs in their Network, with specialist services, with acute hospital services and with service partners by way of shared care arrangements, agreed referral pathways and identified link persons.

Each Network generally supports a number of teams and includes care groups and other specialised resources. Whilst the majority of services will be delivered from within the PCTs, the HSCN will deliver specialist services in response to requests from PCT members and other referral sources. Generally such requests will be in the form of Shared Care protocols and guidelines. As services evolve and develop they will generally fall into three types:

1. **Specialist assessment and advice** – where a specialist reviews the case and provides detailed diagnosis, advice and support when requested to do so.
2. **Shared care** – the health or social care specialist (or team) contribute directly (in their area of expertise) to the care of the patient either continuously or on a crisis intervention basis to support the PCT through the Key Worker who remains responsible for overall co-ordination of the patient's care.
3. **Case management** – where the HSCN based specialist service takes lead responsibility for the care of the individual and they liaise with the patient's PCT as necessary to ensure continuity of care.

The HSCNs will support clusters of between three to six PCTs. Development work to progress this model of service delivery is at an early stage and will continue to focus on strengthening communication links in line with the commitment to develop services on a network basis with the PCT acting as the main hub for service delivery.

Local Health Office Level

Some specialist services may be delivered at Local Health Office (LHO) level or across two or three Networks – for example early intervention teams, child protection teams, child and adolescent mental health teams and so on. Other services may be organised across a number of LHO areas particularly services that require a certain quantum of population greater than an LHO area, i.e. a critical mass of cases is required for clinical, safety or value for money reasons.

Administrative support for Primary Care Teams

Appropriate administrative arrangements are being put in place to support primary care at a local level. In particular the following administrative arrangements are critical to the smooth running of a PCT:

- To provide a single point of contact for patients/clients when negotiating through the PCT and other health services
- To co-ordinate clinical team meetings and any other staff meetings to include scheduling of meetings, venues, documentation/reports for circulation, minute taking, etc.
- To ensure that the PCT has an effective appointment system that works smoothly and efficiently
- To ensure efficient internal and external communication, acting as the focal point of contact between the team members, the wider Network services and the local population, and thus ensuring improved integration between all statutory and voluntary health care providers
- To collate statistical data and information to include management, analysis, interpretation and reporting for submission to HealthStat, management, team members and others as required
- To support the team in the efficient use of resources and in working in a multi-disciplinary team manner
- To work with the team in the identification and management of risks
- To work with the team in reviewing the information available on the services being provided and in the identification of areas for development

1.4 ELIGIBILITY AND ACCESSIBILITY

PCTs should be the first point of access for people who want to access the health system.

Eligibility

Eligibility determination is a policy issue that the DOHC is examining. A National Policy is under consideration at this level on enrolment and eligibility, and existing arrangements will continue until then.

Note: As a Facilitator you will need to discuss this issue with the relevant Heads of Discipline in order that you are familiar with the approach being adopted locally in relation to eligibility. You are not expected to have all the answers on this complex issue – however you will be responsible for gathering the relevant data or questions that emerge and refer them as appropriate to the relevant managers. The managers have a responsibility to adopt a consistent approach and be available to deal with issues as they arise. This is an area that the overarching Clinical Governance/Steering Group will need to attend to.

In general the position being adopted in relation to HSE delivered services is as follows:

- Eligibility will remain as it currently exists in line with existing discipline practices and national guidance
- Clients will be prioritised based on assessed needs within the context of enabling a team response if required

In the case of non-medical card holders/other public card holders presenting for services the following generally applies:

- They are eligible to receive services from the PCT where they reside, even if they opt to receive GP services elsewhere
- They will be prioritised according to need

Access for patients/clients

- PCTs should provide patients/clients with greater access to services by improving the availability of current services through:
 - the reconfiguration of existing health professionals
 - the provision of health professionals based on the health needs of their local population
 - the provision of services currently hospital based within the local community, for example improved diagnostics and prompt referrals to appropriate services and decreased waiting times
 - the provision of standardised protocols and referral pathways
 - extended working hours as required
 - increasing public awareness through posters, community newspapers and notice boards
- Where a client is referred directly to a HSCN, the Network will establish a link back to that client's PCT so that they are fully informed and engaged where appropriate with the client's care. Communication processes in this regard need to be established.

Enrolment/Registration with a Primary Care Team

Note: A National Policy on Enrolment is required. However, as a Facilitator it is important to have some understanding of the thinking and concepts behind this issue.

Enrolment is voluntary. The benefits of enrolling with a team includes better continuity of care, improved co-ordination of services and more attention to preventive services. Methods for enrolment include: the use of opportunistic situations (for example when patients attend their GP for appointments), letters, information leaflets, mail shots, public meetings, local press and information stands. Patients residing in the PCT catchment area and/or patients of GPs practicing in the team catchment area are eligible to enrol with the PCT.

The current practice in some areas is that a geographic model of aligning families to PCTs is in operation – therefore where you live determines the PCT that you receive your services from. The referral process to members of a PCT establishes a link with the relevant PCT and your details are recorded on the PCT data base – this is therefore a registration methodology. Medical card holders are already aligned to a GP in their geographic area and therefore can receive other related PCT services from the relevant team. In relation to non-medical card holders they may choose to select a GP that is not in their area of residence. However, they are required to receive other PCT related services that they are eligible for, from the team in their locality.

1.5 LOCAL HEALTH OFFICE CONTEXT

Note to Transformation Development Officers and Facilitators

As a Facilitator it is important that you are familiar with the local context, i.e. within your LHO area. It is also important that you are familiar with the status of the emerging structural changes associated with the establishment of the Integrated Services Areas. The **Local Implementation Group** is also a significant reference point at local level. In some areas Project Groups or overarching Clinical Governance/Steering Groups have been established. It is critical that you are up to date with the functioning of these groups.

The following information is available from the TDOs in each area and will assist people taking up a facilitation role:

- Population needs assessment and configuration of Teams and Networks based on mapping exercise (maps/diagrams) – number of planned Teams and Networks for your area
- Project/Implementation Plan for the development of primary care services in your LHO area within the context of the overall plan for Dublin North East – infrastructure, ICT, reconfiguration of resources, planned recruitment of additional staff, service and team development, etc.

PART 1 has outlined the core contextual background needed to engage in the development of primary care services. PART 2 now outlines practical guidance to assist you to support teams at each stage of their development.

Part Two

Approach to Team Development – practical guidance

PART 2:

Approach to Team Development – practical guidance

Phase 1 - The Preparation Phase

Phase 2 – The Early Development Phase

Phase 3 – Specific Team Development Modules

Three phases to team development have been outlined in the National Framework: *Team Development for HSE PCTs – Proposal (June 2007)*. These phases and some key interventions for team development are outlined in Part 2 of this document.

Phase 1 The Preparation Phase

Phase 2 The Early Development Phase

Phase 3 Specific Team Development Modules

The phases outlined in this part of the document are interlinked and do not exist in isolation of each other – therefore as a Facilitator you may find that you are referencing different parts of this Guidance Document in a non-linear manner. Therefore, as noted earlier taking a flexible and adaptable approach is important while at the same time being aware of all of the core elements that support effective team working.

PHASE 1: THE PREPARATION PHASE

Key elements of the Preparation Phase

Stakeholder analysis and communication

First exploratory meeting/workshop of Primary Care Team members

First exploratory meeting with PCT members - Session outline 1

During the Preparation Phase the TDO with the LHM, General Manager (GM) and other locally based managers (in particular Heads of Discipline/Service and Administrative Managers) will attend to the key factors that assist in increasing readiness to progress developments within primary care. As noted earlier Project Groups may be established in some areas and they will be a key reference group for early preparation work. It is important that as a Facilitator you are familiar with the outcome of this phase and/or you may be actively engaged in assisting with elements of this work. The overall context for this work is important and therefore being aware of the broader intentions with regard to the Integrated Services Programme and/or the Project Plan for the development of primary care services in your area are all significant reference points for you in your work.

Key elements of the Preparation Phase

This phase is characterised by many meetings and informal conversations with key stakeholders individually and within different professions/disciplines. Experience to date has indicated that the Heads of Discipline/Service play a pivotal role in leading the journey from a uni-disciplinary to a multi-disciplinary model of service delivery. In this regard, they have a responsibility to take up both a leadership and governance role. The focus of the work during the preparation phase is to do the groundwork, scanning for concerns, expectations, opportunities, attending to local organisational politics, sharing information, describing the vision for improved client services and building trust. This early work is vital to planning the more formal meetings for PCTs.

Purpose of the Preparation Phase

- To engage with key stakeholders and to assess their readiness to support the development of primary care services (Reference: *Improving Our Services: A Users' Guide to Managing Change in the Health Service* - Stakeholder Analysis (2008:25), Readiness and Capacity Template (2008:27)
- To begin the process of relationship building across all relevant sectors at local level to increase readiness for change and working together
- To share information and clarify issues regarding primary care services with a view to scoping out an overall **Project Plan** in line with local needs assessment
- To deal with infrastructure and ICT requirements as key enablers to the change process
- To reconfigure existing community services into designated PCTs and Networks, and outline and put in place the necessary staffing resources to enable a team response across all of the relevant disciplines in line with the needs of the catchment area

Stakeholder analysis and communication

Based on the Stakeholder Analysis noted above, some clear indications will emerge in relation to key individuals or groups who require different responses in this early phase – it is important to attend to the information that is emerging and place a particular emphasis on early and consistent communication. (Reference: *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive* - Stakeholder Analysis (2008:25), Communication Plan (2008:40).

Some key actions that may assist at this stage include the following:

- **Working with key service managers to assist them to lead the process locally**

- Local Implementation Group
- Local Project Group which includes relevant Heads of Discipline or other similar structure
- Working with key managers, for example within care groups/specialist services to assess the impact of the change (Reference: *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive* - Impact Assessment (2008:48)
- Working with key managers to plan early exploratory sessions with staff who will be working within primary care services

- **Attending to communication and ongoing engagement**

Communication is critical to effective engagement with key stakeholders during the early preparatory stages in the development of PCTs. A sample communication plan is presented on pg. 42 of this Guidance Document.

- **Attending to readiness indicators**

During the early preparation phase it is important to understand the factors that will increase the readiness for change. It is also essential to create a sense of shared responsibility in order to build a solid foundation for ongoing developments within primary care services. The phase will determine what you will pay attention to and plan for. It assists key managers and in particular the LHM, GM, TDO and Heads of Discipline to get a sense of the breath and depth of the change effort. The activities for change as outlined in *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive* (2008:27,28) are the key factors that impact upon readiness and capacity for change and can be used as a framework for assessing readiness at individual and collective levels. The assessment template outlined in *Improving Our Services* can help focus attention on the areas that must be worked on to create the critical energy needed for change to occur.

- **Attending to induction/orientation for reconfigured/new staff**

Staff joining primary care services may be newly recruited or they may be transferring from other services/teams. Therefore, the induction/orientation phase needs to take account of the different experiences of staff members. The role of the Head of Discipline and/or HR staff in this regard needs to be agreed with an appropriate balance on a uni-disciplinary and multi-disciplinary focus.

First exploratory meeting/workshop with Primary Care Team members

Early exploratory meetings/workshops with staff who will be working within primary care are the first step in enabling the team to come together and begin to function. The focus of these meetings is to provide a forum where all members of the core PCT can meet together to share expectations. It also provides an opportunity for team members together with the LHM, GM, Heads of Discipline and the TDO to discuss and seek clarification on any issues and/or concerns relating to primary care service development.

Exploratory meetings could take place at the level of the Network or with members of PCTs who will be working together on a regular basis. Some PCT members may be located in the same building and others may be more dispersed. In some instances a Chairperson/Team Co-ordinator may be agreed in advance or may emerge from within the group.

Purpose of the exploratory meeting:

- To meet with colleagues and share expectations
- To discuss and seek clarification on issues of concern to members
- To deal with practical arrangements for ongoing clinical/business meetings
- To plan for appropriate engagement with GPs and other key individuals/services

Pre-meeting planning

Discussion with TDO

Prior to facilitating an exploratory meeting with staff it would be important to discuss in detail with the TDO the level of preparatory work that has been completed at local level and possible information needs for staff. This may have included dedicated work with Heads of Discipline, GP engagement, capital development plans, geographic outline of the area, demographic data, status of national guidance documents in relation to referral, clinical meetings, information sharing, etc.

It would also be important at this stage to discuss with the TDO who should lead and be involved in the exploratory meetings – it may be helpful, for example for the Heads of Discipline to lead these discussions and to involve the GM or other locally based staff in these meetings. It is likely that the TDO or a member of the Project Group will call the first meeting of the PCT.

Meeting arrangements

Attention needs to be paid to arrangements regarding timely notice, venue arrangements, refreshments, minutes and follow up, etc. The issue of administrative support for the team also needs to be considered.

- What key supports can be made available to the team to assist them to be effective from an administrative and organisational perspective? The locally based lead Administrative Manager and the TDO will have discussed this issue in advance, and as a Facilitator it is important that you are briefed in this regard
- The involvement of GP and practice staff at an early stage is important, and the most appropriate levels of engagement can be agreed locally and in consultation with the TDO in advance of this exploratory meeting

Managing the meeting

It is important for this early meeting that there is some prior discussion regarding chairing/co-ordinating/leading the meeting and some sense of how this will be managed on an ongoing basis. The issues of leadership, administrative support and GP/practice staff participation are likely to be early agenda items for the team as noted above.

- What consideration needs to be given to addressing these issues within the team? These issues may emerge during early sessions with team members and it is important to provide some guidance in this regard taking account of the national position and input from the TDO and Heads of Discipline
- There will also be a need to be aware of national requirements/expectations with regard to ongoing PCT development

Sample session outline 1 - First exploratory meeting with PCT members

Purpose of the exploratory meeting/s

- To meet with colleagues and share expectations
- To discuss and seek clarification on issues of concern to members
- To deal with practical arrangements for ongoing clinical/business meetings
- To plan for appropriate engagement with GPs and other key individuals/services

Format for exploratory meetings

It is suggested that Heads of Discipline with the assistance of the TDO manage the exploratory meeting. It is important to model a multi-disciplinary approach, and therefore for example the Heads of Discipline may agree among themselves the roles that they will adopt at these early sessions. It is likely that they will deal with (a) and (b) noted below. This will include introducing the Facilitator/s (the locally based resource person and other Facilitators) and clarifying their roles. It may emerge that one of the Heads of Discipline may take on the lead role of Facilitator for this phase of the work. **The suggestions outlined below may take a number of sessions.**

Possible format for exploratory meeting/s

- Welcome and introductions.
- Update on local PCT developments within national context.
- General discussion – will need to be facilitated and allow plenty of time – this general discussion may provide an opportunity for participants to share their expectations – hopes, concerns and challenges (The data gathered in this session will assist in preparing for the dedicated follow up sessions with teams).
- Agree an initial format for clinical case discussion/clinical meetings.
- Agree next steps and schedule the first meeting for the PCT.

See notes below for further expansion on these points.

a) Welcome and introductions

In preparing for the opening part of the meeting it is important to remember that some people will know each other, others will have years of experience of working in community care, some will have experience of team working and others may be newly recruited staff – expectations and perspectives will vary. It is important to be aware of the history or legacy that exists as this will shape the culture of the group moving forward. As a Facilitator you also need to be tuned into these dynamics and be clear about your responsibility to progress the discussion towards

a team approach to primary care service delivery. It is also important that you bring a sense of reality to the discussions by demonstrating a sense of the local context and realities for staff.

b) Update on local PCT developments within national context

At the first or second exploratory meeting it may be decided to ask someone with PCT experience to share their learning in relation to their participation in the team - identifying what worked well, what barriers were encountered and how they were overcome, what might have been done differently, etc. The TDO or nominated person may also be asked to present an update on the local position and status of factors such as accommodation, recruitment, ICT, funding, etc., in addition to information that has emerged from preparation meetings, i.e. questions/concerns/issues that were raised and/or other factors that were highlighted. These updates need to be structured in order to ensure that participants have sufficient information and to enable discussion.

c) General discussion

This is the key information gathering part of the exploratory meeting - it is important to provide all the participants with the opportunity to share their views. There are no right or wrong answers and all views are valid. Some prompt questions include the following:

Prompt questions

- What are your hopes/expectations for the development of this PCT?
- What are your concerns/main challenges for the development of this PCT?
- What factors do you think would assist you to work effectively as a team?
- What would you like to achieve as a team within the next month/next three months? This will give an indication of where the team wants to start in terms of working together

It may be helpful to encourage people to consider each of these questions individually in the first instance before opening up the session to a group discussion. Therefore, the questions noted above may be given as a handout and will also need to be pre-written on a flipchart to assist in gathering the feedback.

- Depending on the size of the group you may decide to have a large group discussion or break into smaller groups – the latter will require identifying a discussion leader/someone to feedback
- In taking feedback it is important to flipchart the data and summarise the key messages for each of the questions noted above
- Following the session, the data will need to be written up and shared with the participants
- This information will also be very helpful in informing and designing the next session with teams

d) Agree an initial format for clinical case discussion/clinical meetings

It is likely that the team members will be keen to commence clinical case discussion as early as possible. Ideally guidance should be available from the Heads of Discipline on the format of clinical meetings – in some areas Heads of Discipline have developed **Standard Operating Procedures for Clinical Meetings** in consultation with staff. However, there is also a benefit in assisting team members to get started without too much formality or regulation. In this regard, team members will need practical assistance in working out the following:

- What is a good way to structure the meeting?
- What cases should we discuss – how to prioritise cases for discussion?
- What information do we need to bring to the meeting?
- What guidance needs to be provided on sharing information on clients - both verbal and written information?
- Will shared files eventually be used?
- What minutes need to be taken? Who will take them?
- How best can we involve GPs in the process?

The above prompts may seem like very basic data – however in order to give the team members the best chance of success it is important that clarity is reached on these areas. Over time the Heads of Discipline/Service in co-operation with team members and based on the national guidance will develop a standardised approach to a number of key areas such as Clinical Meeting and Clinical Processes. In the interim however teams will benefit from overall guidance and encouragement to make a start and learn from the process.

*(As noted earlier some areas have developed **Standard Operating Procedures** – sometimes referred to as SOPs – it is important that the introduction of these procedures is discussed with team members. Copies of the locally adapted SOPs are available from the TDOs).*

e) Agree next steps and schedule the first meeting for the PCT

As a Facilitator you will already have a broad sense of what the next session might look like and who will be involved. You therefore need to take on board the output from the discussion that has just taken place and provide a sense of how this information will be used to plan the next steps and/or the next team discussion/session.

If, for example there were some clear information gaps (position on administrative support, team leadership) this data could be gathered and shared with participants following the meeting and/or be attached to the write up from the session when it is being circulated.

Some of the likely responses from the discussion may include the following:

- We want to be clear about our purpose
- We need clarity on roles and responsibilities – we don't know what other people do
- We need good communication or decision-making processes
- We want to share information on client groups or we want to get started with clinical meetings
- We would like to develop a profile of our local community or a directory of services
- We want to start using the common referral form

As a Facilitator and with the assistance of the TDO you will need to provide a sense of what will happen next and what format it may take.

Follow up

Ending sessions is important and attention will need to be given to follow up that may emerge. This may consist of debriefing with the TDO and may then involve individual follow up with some of the participants and/or with Heads of Discipline and team members. Teams may wish to start meeting themselves to commence clinical discussion on shared cases. It is important that in addition to the commencement of clinical meetings that time is also dedicated to follow up on the team developmental agenda.

PHASE 2: THE EARLY DEVELOPMENT PHASE

Background information on teams

What do we mean by team working
Definitions of team working
Model for Effective Team Working

Early assessment of need – where to start?

Identifying early development need - Session outline 2
Identifying development needs for more developed teams - Session outline 3
Increasing understanding of team working - Session outline 4

Targeted development areas for teams

Establishing ground rules

Establishing Ground Rules - Session outline 5

Developing clarity of purpose

Developing Clarity of Purpose - Session outline 6

Clarifying roles

Role Clarification and Self-Assessment - Session outline 7

Establishing processes for working together

Description of the Client Pathway
Overview of clinical team meetings
Communication Plan Template
Establishing goals and performance measures for the team – Session outline 8
Improving decision-making processes within the team - Session outline 9
Establishing team based-prioritisation processes - Session outline 10
Reviewing team functioning - Session outline 11
In-depth review of PCT performance - Session outline 12
Stages of team development
Increasing understanding of group development - Session outline 13

The Early Development Phase

This Early Development Phase relates to the initial development of the team and outlined below are possible interventions that may be appropriate during their first meetings. However, it is important to note that the team itself should 'set the pace' and may in many instances not require any formal intervention. Allowing teams time to get started, knowing that support is available when needed is often the most effective way to proceed. As a Facilitator you need to gauge your level of involvement at this stage and you may find that the best approach to adopt is to work with the Team Co-ordinator/Chairperson to plan meetings and trouble shoot issues as they emerge (see pg. 34 of this Guidance Document). In some areas Heads of Discipline have taken up the role as lead clinician to support teams in their early development. The TDO in your area will be able to advise you in this regard.

However, at some stage in the early development of all teams it is important that they take time to consider what they actually mean by team working and the core components of effective team working. It is also likely that the team members themselves will have referenced the need for this type of work during their exploratory meetings/sessions, i.e. seeking clarity regarding shared purpose, roles, team processes, etc. As a Facilitator you will need to consider where best to start and perhaps the best approach is to ask the teams themselves what they think might be helpful.

Background information on teams

To assist you as a Facilitator in this stage of your work some background information is outlined below. This is not intended to be a comprehensive outline of all the information that you may need – however it covers some of the basic data that teams to date have requested.

What do we mean by team working?

The term 'team' can be used to describe 'a group of people who share common objectives and who work together to achieve them'. They share the following characteristics in line with the Model for Effective Team Working presented below on pg. 28: *(Characteristics adapted from West and Markiewicz, 2003)*

- A shared vision of how the service should be delivered
- A common, agreed, shared purpose
- They share objectives and targets
- They have well-defined and unique roles
- They have the necessary authority, autonomy and resources to achieve the team objectives
- While team members may work independently in some respects, they have to work closely and inter-dependently with other team members to achieve their shared objectives
- They are recognised as a team

Definitions of team working

Teams in health and social care are generally described as 'multi-disciplinary'. In many cases staff will be members of their own discipline team as well as a multi-disciplinary team. Other frequently used terms included inter-disciplinary and trans-disciplinary. The distinction between the terms refers to the

ways in which the team approaches contributions from different disciplines, the extent of discussion that takes place within the team, the level of collaboration between team members, and to what extent team members achieve a sustainable common language. It is acknowledged that many areas within health and social care have extensive knowledge and experience of different models of team working. This Guidance Document provides an overview of definitions – however to fully appreciate the nature and complexity of models of team working and to understand more fully how they operate in practice, Facilitators would be advised to consult with colleagues in areas where developed models of team working are in use.

Definitions of team working

Some commonly used definitions are noted below: (*Source of definitions: Team working in the NEHB, Discussion Paper, May 2003*).

Unidisciplinary teams are made up of one discipline, i.e. nursing, physiotherapy, psychology, etc. In some contexts a uni-disciplinary response may be the most appropriate approach to meet the needs of clients/families, i.e. an individual may require the intervention from one team member.

A **multi-disciplinary team** is identified as ‘involving a combination of several disciplines and methods’. It refers to a team or collaborative process where members of different disciplines assess or treat patients/clients independently and then share the information with each other. Multi-disciplinary working is characterised by parallel work where each discipline may operate quite independently from the other.

The term **inter-disciplinary** means ‘involving two or more fields of study’. It describes a deeper level of collaboration in which processes such as evaluation or development of a plan of care is done jointly, with professionals of different disciplines pooling their knowledge together in an independent manner. In an inter-disciplinary context, disciplines share common goals, are committed to communicating and working through planned interaction, client involvement, better co-ordination of tasks, etc. Members of the group begin to use the language of other disciplines.

Trans-disciplinary is explained as ‘across; beyond; through’. In a trans-disciplinary model common goals are shared and disciplines plan together using systematic processes. Sharing roles and working across disciplinary boundaries is a key feature. Patient/client participation in decision-making is seen as a crucial element in trans-disciplinary working. A trans-disciplinary team is characterised by integrated thinking based on the sharing of knowledge and a greater blurring of professional boundaries than in inter-disciplinary teams.

It is important to note that while these definitions may be helpful, the actual process of team working is not so clearly defined in reality. In some instances team members may find that they are working along the continuum noted above and that they adopt different approaches depending on the needs of the client/client group. However, the concept of a continuum is useful and may support team members to consider how they are functioning along this spectrum. The level of collaboration between team members is one of the defining criteria used above and perhaps for some teams in the early stages of development it may be helpful to consider how well they are doing in terms of basic information sharing, providing feedback, consulting on shared care arrangements and so on.

Model for Effective Team Working

The Model for Effective Team Working presented below is the core reference point for team development processes in Dublin North East. It has been developed over a period of time with staff and colleagues across the area and is in line with the core components for effective team working and the definitions of teams noted above.

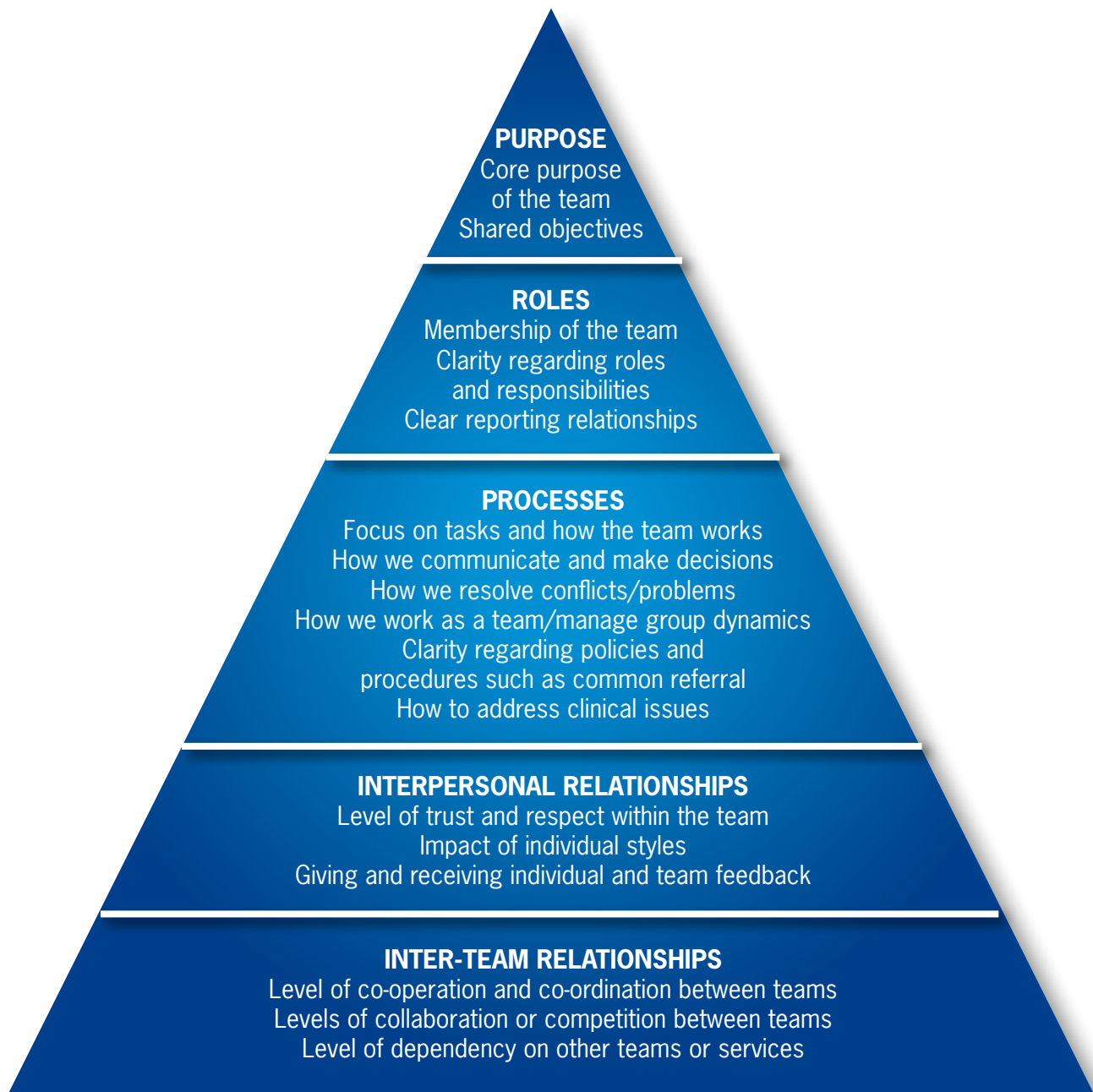


Figure 2: Model for Effective Team Working

Adapted from *A Health Strategy for the People of the North East*, 2003

The essence of the Model for Effective Team Working is that it focuses on clarity of purpose for the team as the significant context and core reference point for all of the team's activity. It then places a strong emphasis on the need for clarity of roles and work processes. Attending to these significant foundations will assist in building inter-personal relationships within the team and relationships between other teams and services.

Early assessment of need – where to start?

The needs of individual teams at an early stage of development may take some time to emerge and the team itself may not be clear on what it requires to assist its development – the Facilitator can therefore prompt discussion with key questions based on the Model for Effective Team Working presented above.

Sample session outline 2 – Identifying early development needs

Purpose: To assist the team to identify its early development needs.

Early assessment of need – this is more appropriate for teams at 'start up' stage

- As team members are you aware of the team purpose and its key goals?
If not, what steps can you take to address this?
- Are you clear about your individual roles and responsibilities and those of team members?
If not, what steps can you take to address this?
- What key processes do you think you need to address to make working together more effective?

Alternatively some teams may have been meeting for a period of time. You may therefore decide as a Facilitator in consultation with the Co-ordinator/Chairperson that carrying out a **SWOT analysis** may be helpful in order to gather key information to determine next steps for the team.

Sample session outline 3 – Identifying development needs for more developed teams

Purpose: To assist more developed teams to identify their development needs.

SWOT Analysis – this is appropriate for teams that are established for some time

Strengths: What do team members perceive to be the strengths within the team?
What is working well?

Weaknesses: What do team members perceive as weaknesses within the team?
What is not working well and needs to be improved?

Opportunities: What opportunities can team members identify to assist them to develop?
These opportunities may be within the team or outside the team in the wider context?

Threats: Can the team identify factors that they see as threats to the team's ongoing functioning or performance?

What do you do with this information?

A SWOT analysis on its own is not sufficient. As a Facilitator you have a responsibility to work with the team to see what this information is telling you and shape it into an action plan. Therefore, agreement needs to be reached on who will write up the outcome of the session. There will also be a requirement to agree the process for sharing the outcome of this analysis with relevant managers in the system.

Having gathered the core data from a SWOT analysis it is important to group the data into themes and prioritise them according to the impact upon the team or service. It should then be possible to analyse the information further in order have a sense of the actions that need to be taken. For analysis purposes the following may be helpful.

For **strengths and weaknesses**, possible questions asked are:

- What are the consequences of these strengths or weaknesses in terms of team functioning and in terms of the service being delivered?
- How can our strengths assist us in achieving our purpose?
- What actions do we need to take to address the weaknesses/gaps we have identified?

For **opportunities and threats**, the questions are slightly different:

- Having identified the opportunities for the team – how can these opportunities act as leverage points for ongoing development?
- In relation to perceived threats – how can these be addressed? What level of control or influence do we have over the threats we have identified? Will they help or hinder us in achieving our purpose?

The above analysis will assist the team to identify a set of priorities for ongoing attention.

Team working definitions as a reference point

It may be helpful for some PCTs who have been established for some time to use the definitions noted earlier (see pg. 26) as a reference point to increase their understanding of team working. It is important however to acknowledge that in some instances it is completely appropriate for team members to work in a uni-disciplinary manner with some clients.

Sample session outline 4 – Increasing understanding of team working

Purpose: To increase understanding of team working.

Using definitions to create a common understanding of team working

The key question for the team may be to consider what model of team working they think is required to deliver the most effective levels of service delivery to the various client groups within primary care. The definitions in this case simply act as a prompt to assist discussion. Outlined below are some prompt questions that may be helpful:

- How do you see yourselves currently working in comparison to the definitions for team working?
- What examples can you give to demonstrate this?
- What approach to team working do you think would be most effective in meeting the needs of your client groups?
- Are different approaches to team working required depending on the nature of the client group? If yes, can you describe these approaches?
- What factors would assist you to work more effectively as a team, i.e. to achieve a more satisfactory team response? This final question should help you to outline an action plan and should be recorded as a reference point for ongoing development

Targeted development areas for teams

Based on what emerges from the needs assessment or SWOT analysis and also the Model for Effective Team Working it is likely that the focus of the early team development sessions will include the following:

Focus for early development sessions

- Establishing ground rules
- Developing clarity of purpose
- Clarifying roles
- Establishing processes for working together
- Attending to inter-personal and intra-team relationships

It may be helpful to present the Model for Effective Team Working as a framework that will anchor the team development process at this stage (see pg. 28 of this Guidance Document).

Possible session outlines are presented below.

Establishing ground rules

Agreeing ground rules for working together, i.e. ensuring participation of all members is a solid place to begin team development. Therefore, it may be helpful to start with establishing ground rules as noted in the session outline below.

Sample session outline 5 – Establishing ground rules

Purpose: To assist the team to develop ground rules for how they will work together – this will enable the team to develop a climate of trust.

Materials needed

Flipchart, markers and blue tack

Note for Facilitator

- Ask the team what ground rules do we need to develop a climate of trust and to work well together
- Get the team to name what is important to them, don't give them rules - they need to name and own their own rules
- Record feedback as given by participants
- Clarify key points and tease them out with the group, i.e. clarify what key words mean for them

For example:

Confidentiality

- What does this mean for us in terms of service user details, record keeping, discussions within the team and what is agreed needs to be brought outside the team, etc.

Time keeping – team meetings

- When will meetings take place, agree start and finish times
- Agree core number to get started
- Agree process to deal with late comers and absent members – how will they be advised of the meeting (if agreed)
- Recording and distribution of minutes of team meetings - how will this happen?

Use of the ground rules

- Use the ground rules on an ongoing basis as a working tool to address issues that may arise for the team
- Display them at each meeting and refer to them when necessary
- At the stage of agreeing ground rules get the commitment from the team to challenge team members if they are ignoring these rules
- As a Facilitator when the team has completed and discussed ground rules ensure that key rules have been included, name them if necessary
- Advise the group that they can add to or amend the ground rules at any stage
- Review the ground rules with new team members and invite them to add to these

Adapted from Children and Family Services Training Team, Dublin North East.

Developing clarity of purpose

Purpose of the team

Having a common understanding of the purpose of a team is critical to its success, “why do we exist?” This shared purpose may consist of core *terms of reference*. There is also a need for a shared understanding of *core values* that will shape how members of the team will work together. Some of the shared values may be similar to the ground rules outlined earlier and include trust, respect, openness, honesty and a willingness to review and evaluate how the team is working. The principles and overall objectives for Primary Care Service Development as outlined on pgs. 7, 8 of this Guidance Document are a useful reference point for this discussion.

Sample session outline 6 - Developing clarity of purpose

Purpose: To help participants think about the core purpose of the Primary Care Team.

Materials needed

- Preparatory Questionnaire for each team member (see below)
- Flipchart, markers, blue tack

Preparatory Questionnaire for Primary Care Team

1. What do you see as the benefits of PCTs?
2. What are the main challenges facing the team?
3. What do you think the core purpose of the PCT is? Why does the team exist?
4. What worries you most or is your biggest concern about working on this team?
5. What is your greatest hope for this team?
6. What would you identify as the guiding values for your PCT?

Using Preparatory Questionnaire for Primary Care Teams

- Divide the team into small groups or pairs; ask them to work together on completing the questionnaire – outlined above
- Take feedback from each group or pair and record the feedback on a flipchart
- Highlight emerging themes from the feedback and discuss with the group
- Agree any actions arising for the team, how these will be addressed and by whom
- Agree who will write up the outcome from this session, i.e. the shared purpose and associated action plan
- Describe a pathway for issues that cannot be resolved at this time - how will these be managed and by whom?
- Plan who will feedback on the agreed actions (if any) at the next meeting

Adapted from Children and Family Services Training Team, Dublin North East.

Roles and responsibilities

Clarity with regard to roles, responsibilities and accountability of individual team members and the team as a whole is critical to its success in addition to clarity with regard to reporting relationships. It is important for all team members to have a good understanding of each other's roles. Challenges will emerge on the 'boundaries' of roles and teams, and in particular when there is overlap in the work practices of individual team members or other teams. This area of 'greyness' can often pose the most significant challenge to effective team working. It is therefore important that time is taken to address role clarity, reporting relationships, issues of overlap and management of boundaries.

Clarity with regard to the allocation of work amongst team members is also important, in addition to having the appropriate mix of skills within the team. It is acknowledged however that within primary care services the range of skills required is quite broad. It is therefore important that team members know how to access support from colleagues in other teams and/or services. It may, for example be appropriate for members of specialist teams to work alongside PCT members in the management of some clients.

Leadership within teams

A strong emphasis on the need for a facilitative approach to the leadership of teams is advocated in relation to PCTs. The importance of creating a flatter structure in teams with greater levels of equality between team members is seen as conducive to effective team working. In some instances the role of Chairperson or Team Co-ordinator may be agreed upon by team members in order to support the smooth running of the team. Experience to date has indicated that teams themselves have recognised the value of this role and have agreed on a rotational basis that different members will take up this role for an appropriate period of time. The inherent role of administrative staff as core members of the team has also been clearly demonstrated as a key enabler to self-managed teams.

Co-ordinators/Chairpersons therefore take up an informal leadership role and as leaders will need to attend to the relationships developed with team members. They must be regarded as a useful resource rather than as someone in charge. It is important that this leadership role is supported by relevant Heads of Discipline in order to appropriately address multi-disciplinary issues that may emerge.

Consideration is being given at national level at present to the overall Governance and Management of PCTs and Networks. There is clearly a need to attend to the interface and integration issues between teams and services both within the HSE and other agencies/communities. Many of the issues related to the management of client care will be attended to by teams themselves. It is important that teams take responsibility for setting their own work goals, establishing schedules/time frames for work, evaluation, performance targets and so on. However, there will be a requirement for other management related issues to be addressed within the overall clinical governance structure that is emerging.

Areas to be clarified regarding roles and responsibilities

Exploring roles within the team and relationships with members of other teams and services will assist the PCTs to function more effectively. Areas to be explored include the following:

- Description of their clinical roles
- What individual team members actually do on a day-to-day basis?
- Description of their client group
- Description of where they work
- Outline of their current referral and prioritisation processes
- Exploration of the differences/similarities between roles on the PCTs and teams within the wider network/specialist services
- Role of the Chair/Co-coordinator, etc.
- Role of the overarching Clinical Governance/Steering Group

Sample session outline 7 - Role clarification and self-assessment

Purpose: To offer each team member the opportunity to clarify their role for all other team members and to self-assess where they are at now at this stage in the development of the team.

Role Clarification and Self-Assessment Questionnaire

Discipline _____

1. What is your role?
2. What are the five key tasks in your role?
 - (i)
 - (ii)
 - (iii)
 - (iv)
 - (v)
3. Can you describe your typical client group?
4. Where do you work?
5. What do others think your role is that it's not?
6. How do you currently receive your referrals? How do you prioritise cases?
7. What does your role bring to help achieve the purpose of the PCT?
8. What will be different about your role now when working as part of this team?
9. What help do you think you'll need in making this change?

Note for Facilitator

- Distribute questionnaire (sample above) and ask each team member to complete it individually, ideally it is helpful to give these to the team members in advance of the session so that they can give it some thought
- If you have two members of one discipline on the team it will be useful for them to share their completed questionnaire in advance of feedback
- Allow each team member to meet and share their feedback in pairs – ask them as they do this to pay particular attention to:
 - Something they were not aware of about this discipline
 - Anything they need further clarification on from a colleague
- Take feedback from the group on questions 6, 7, 8 and 9, and discuss
- Agree if a write up is necessary
- Get permission from the group to copy their feedback, it will be useful in the induction of new team members
- Agree how the information gathered will be used

Adapted from Children and Family Services Training Team, Dublin North East.

Processes: Establishing processes for working together

Clarity with regard to how people work within a team and how the team works is essential. A PCT exists to deliver joined up services to its population/client groups, therefore this will have an impact on how services are organised. In particular there will be a need to focus on core clinical processes associated with the shared client journey/pathway. This will have an impact on how the team organises its clinical processes such as referral, prioritisation, waiting list, assessment, caseload management processes and so on. In addition to these clinical processes the team needs to attend to core processes related to how members of the team work together such as those outlined below.

Core processes to enable effective team working

- How working together will be organised, i.e. frequency of meetings, commitment to attendance at meetings, etc?
- How communication takes place, i.e. how information will be shared, how communication takes place between members of the team?
- How the team interacts with other teams, departments, functions on a regular or needs basis? How communication with other teams/services takes place?
- How the team interfaces/communicates with its client group and local communities?
- How decisions will be made within the team?
- How objectives will be agreed and performance measured?
- How risks will be identified and managed?
- How conflicts or problems will be resolved or managed?
- How the group works as a team with a particular emphasis on group processes and group dynamics?

- How successes/achievements of the team are acknowledged?
- How the team evaluates its progress?

Guidance to assist teams to develop their thinking in relation to these processes is outlined in more detail later in this section. Teams can also request specific team development modules from Performance and Development as outlined in Phase 3 (see pg. 54). Staff working within risk management may also be able to assist teams in risk identification and quality, safety and risk management.

National guidance on core processes

National guidelines have been developed in relation to core areas such as:

- Common Referral Form and Referral Guidelines
- Clinical Meetings
- Information Sharing

All of the above documents are available from the TDO locally.

These national guidelines may already have been revised to suit the local context and/or teams may wish to use them and apply them in accordance with local needs in order to develop **Standard Operating Procedures** for teams. This process of development requires the engagement of Heads of Discipline and PCT members. It is also important that these procedures are signed off by local management.

Some core areas that will require attention from both managers and staff at this stage in the primary care service development process include the following:

- **Managing the client pathway from referral to transfer of care or discharge**
- **Processes for clinical/team meetings**
- **Managing communication processes within the team and with other teams/services**
- **Processes for setting team goals and measuring performance**
- **Decision-making processes within the team**
- **Establishing clinical prioritisation processes** – appropriate for more established teams
- **Review/evaluation processes** – appropriate for more established teams

Managing the client pathway from referral to transfer of care or discharge

The client pathway (Figure 3 - see pg. 38) from referral to intervention and discharge requires particular attention by team members and Heads of Discipline with particular reference to the following:

- Referral processes – use of a common referral form
- Intake/initial assessment processes
- Joint interventions/therapy/shared care processes
- Transfer or discharge processes

As a Facilitator you may be taking the national guidance on the client pathway as adapted jointly by the Heads of Discipline and team members and working with the team on its implementation. (As noted earlier some areas may have developed a **Standard Operating Procedure** to address this aspect of the client pathway). In many instances the team may be well able to carry out this work themselves and/or they may require the support of a Head of Discipline/Facilitator to assist them to apply the guidance to their day-to-day work.

Description of the Client Pathway

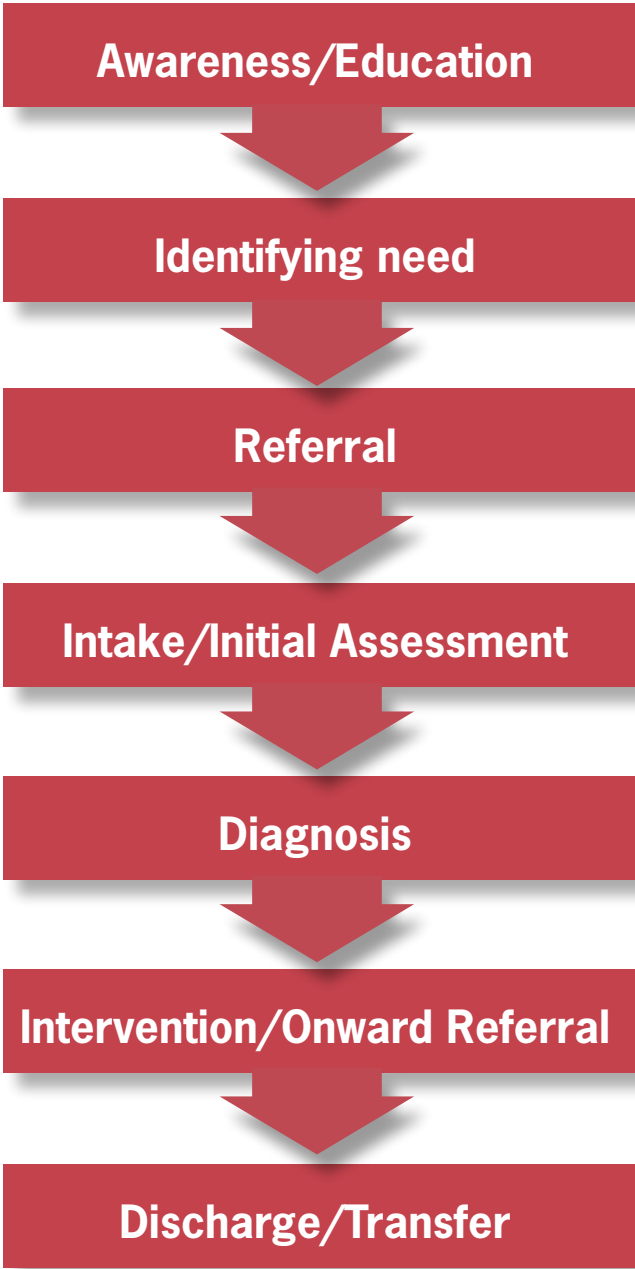


Figure 3: Client Pathway

Referral process

In some areas progress has been made on the introduction of a Common Referral Form for Primary Care Services. This form facilitates referral sources to use one form to refer to services such as Public Health Nursing, Occupational Therapy, Physiotherapy, Clinical Psychology, Speech and Language Therapy, Social Work and so on. The administrative and ICT support required to enable the common referral process to work efficiently and effectively is critical to its success. The introduction of the Common Referral Form is a significant development and signifies the commitment to streamline access to services and promote a team approach from the outset. **Standard Operating Procedures** have been developed to support the referral process and progress has also been made on describing the client pathway from initial assessment through to intervention. The TDO will have access to relevant documentation in this regard.

Processes for clinical/team meetings

As noted earlier it is likely that team members at a very early stage will want to commence clinical case discussions. This may take place prior to any formal discussion on how clinical team meetings will be managed. However, it is important that team members take time to discuss the purpose of team meetings and agreed core components such as clinical, business or developmental focus; frequency and length of meetings, etc. They may, for example divide their meetings into relevant parts:

1. Business/operational issues relevant to the team.
2. Intake discussion – new referrals to the PCT.
3. Case discussion – ongoing cases discussed.

Therefore, designing and agreeing a framework/process for clinical meetings would be helpful. This needs to be completed jointly by Heads of Discipline and team members. In this regard, reference to the National Guidelines on Clinical Meetings will be essential and again in some areas they have already developed a **Standard Operating Procedure for Clinical Meetings** – your locally based TDO will have relevant information in this regard. Some of the core concepts are outlined below.

Overview of clinical team meetings

The underlying principle for clinical team meetings is to deliver seamless, comprehensive care to the individual by the PCT including, where appropriate, inputs from specialist services. Clinical team meetings provide the opportunity for different professionals to share their skills thus enabling the provision of a wide range of services and resources for service users.

- The **purpose** of the clinical meeting is to bring the PCT together in order to:
 - Respond to the needs of individuals and families when problems or acute needs are experienced
 - Exchange information for the effective management of client needs
 - Co-ordinate ongoing care for individuals and families
 - Develop a multi-disciplinary care plan
- Each clinician will retain **accountability** for their work in accordance with their professional standards and will have responsibility for their contribution to the care of the patient/service user/client/family

- The **frequency of meetings** will be based on need and determined by each team, at a minimum teams should meet formerly on a monthly basis
- It is the responsibility of the team member to obtain **consent** from the client/carer for discussion at the clinical team meeting. In some instances this consent may have been obtained at the stage of referral
- The team should agree which member of the team would be appropriate to provide **feedback to the client**. If a Key Worker has been nominated this person will take up this role
- Each team member should **prioritise** the clients they wish to discuss and give a list to the Chairperson/Co-ordinator prior to the meeting
- **GP involvement** in clinical team meetings and follow up is an area that will require consideration at local level in terms of best accommodating the needs of all team members and facilitating comprehensive case discussion
- It would be appropriate for the team to consider how best to develop a **multi-disciplinary care plan** for clients with complex needs or chronic diseases. These plans typically define the services required, the timeframe, the person responsible and a review date
- The team needs to agree how records of the meeting will be recorded both in terms of clinical notes and administrative/business decisions. The Chairperson/Co-ordinator in liaison with the administrative support staff can progress this issue and can refer to national/local guidelines in this regard. A **summary report**, for example can be completed on each client discussed to include the actions agreed
- It is the responsibility of each professional to ensure that their **clinical notes** are updated in accordance with the summary report
- The concept of **shared files** requires discussion at local level to see what progress can be made in this regard
- Teams locally need to consider the role of **Key Worker**. Any clinical member of the team/network can undertake the role of Key Worker. The Key Worker is the person nominated by the team to:
 - Link the person into the services
 - Co-ordinate service delivery in accordance with the summary report
 - Communicate with the client on behalf of the team
 - Act as lead contact for the client and other staff and professionals
 - Link with Key Workers in other services as required, e.g. disability services, mental health services, etc.
- It is important that team members are aware of the requirements on the team to attend to **performance measures**. Some of these performance measures are agreed nationally and others may be part of individual discipline requirements. The Heads of Discipline and TDO will collectively have a good sense of what is required. The role of the administrative support staff in collecting and co-ordinating the relevant information is critical
- Teams will also be required to attend to the HSE **Integrated Quality, Safety and Risk Framework** as part of their overall clinical governance and service improvement commitments

Managing communication processes within the team and with other teams/services

Communication is critical to effective team functioning, and particularly in relation to building relationships within the team and externally. It may be a helpful exercise for the team to map out the key stakeholders that they typically interact with as part of their core work. They can then consider their communication needs, i.e. what they need to know about the team or service and also how best to communicate with these individuals or groups. The key stakeholder groups will include:

- Colleagues within the team/HSE
- GPs and practice staff
- Other disciplines, teams and services
- Other sites and different locations
- Service users, families and local communities
- Referral sources
- Key agencies at local level

The following template taken from *Improving Our Services: A Users' Guide to Managing Change in the Health Service Executive (2008:40)* addresses key prompt questions that will assist the team to examine and improve their communication processes. They may wish to explore:

- What is working well in terms of communication processes?
- What areas can be improved?

Communication Plan Template

WHO: Who do you need to communicate with? (Stakeholder mapping was referenced earlier on pg. 20)	WHAT: What is the purpose of your communication? Information gathering: What information do the different stakeholders need to know about the PCT/ service? What do you need to know about this individual/group or service? Information sharing on the following: Referral data Individual client data Client group data Service data Administrative/ business data Performance data What is the content of your communication? What message do you want to give?	HOW: What is the most appropriate method or means of communication? Methods of communication: Face-to-face communication if possible is the most effective means of communication for building relationships <i>Other means of communication:</i> Individual/team meetings Written communication – letters, reports, summary reports, etc. Email Telephone Video conferencing Service directories – names of staff and contact details; outline of locally based community groups and services; geographic mapping the area being covered by the PCT, etc. Induction information for new staff or for other teams/services	WHEN: How frequently do you need to communicate? What is the best timing? Follow through and consistency in terms of communication is important in addition to attending to the best timing for communication to take place	OUTCOME: How will the impact and effectiveness of the communication process be assessed and acted upon? It is important to check in with your key stakeholders regularly to see if your communication methods are effective and to consider what improvements may need to be made	WHO: Who is responsible for the communication action? Clarity with regard to communication follow up is essential and should form part of regular meetings and case discussions
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Processes for setting team goals and measuring performance

Having agreed your purpose and established appropriate structures and processes for doing work - the team can now consider how best to set goals in line with their overall purpose. Setting high level goals in line with the purpose and overall objectives of the primary care service is a key step. In this regard, you may wish to reference earlier work on *Clarifying the Purpose of the PCT* (see pg. 33 of this Guidance Document).

Appropriate performance measurement systems/performance indicators also need to be developed. As noted above it is important to be aware of national and local requirements. The TDO will be able to assist you in this regard. A more detailed action/service plan for the short and medium term can then be outlined to assist the team to remain focused on joint objectives throughout the year. The overarching Clinical Governance/Steering Group has a role in distilling the national guidance and assisting PCTs in translating these targets into tangible actions at local level.

Sample session outline 8 – Establishing goals and performance measures for the team

Purpose: To establish goals and performance measures for the team.

The advantages of goal setting include the following:

- Provides clear direction
- Helps to clarify roles of team members
- Provides a focus for communication and review
- Clearly indicates success and areas for improvement
- Facilitates a sense of achievement for the team

The steps required to agree goals and an action plan include the following:

1. Can you identify and agree the **key goals** for your team in line with national and local requirements?
2. Can you now agree **objectives** in line with the goals? Objectives are specific statements of the outcomes the team plans to achieve. There may be a number of objectives related to each goal. The objectives say:

- What will change or be achieved?
- In what way/by how much?
- When/by what date?
- When it will be reviewed?

Remember objectives must be:

- Realistic and clear
 - Specific and timed
 - As concrete as possible
 - Measurable and achievable
3. You now need to agree the **performance measure/performance indicator** for each objective – this is a marker by which the team can measure progress towards achieving the objectives.
 4. You can now agree an **action plan** to achieve the goals for the team – for each objective you need to identify key tasks and assign **responsibility** for implementation.
 5. You also need to set **time scales** and clarify what **resources** will be used.
 6. It will also be necessary to consider possible **risks and dependencies** – what are the main risks associated with each goal/objective; what are the main dependencies that may impact upon achieving the goal/objective?

An action plan template will include the following key headings:

Goals	Objectives	What actions/tasks are required?	Who is responsible?	Level of priority and timeframe	Performance measures	Resource requirements	Risks and dependencies

Adapted from *Improving Our Services: A Users' Guide for Managing Change in the HSE* (2008:52).

Many team members will be familiar with the concepts and headings outlined above. However, it is acknowledged that it is often helpful for someone outside of the immediate team to assist the team members to prepare an action/service plan. This may be a Head of Discipline/Facilitator working alongside the Team Chairperson/Co-ordinator. In some instances a session on team-based performance management or a related course on service planning may be helpful. Locally it should be possible to explore what supports are available in this regard from the Performance and Development Team. Assistance may also be available within the context of implementing the Integrated Quality, Safety and Risk Framework. TDOs will be familiar with supports available locally.

Decision-making processes within the team

As many of the decisions to be reached within primary care will be clinical in nature it is important therefore that the team takes time to consider the implications of making team-based decisions. In this regard, the role of the overarching Clinical Governance/Steering Group at local level is significant in terms of providing guidance in line with national and professional standards of practice. Heads of Discipline have a responsibility to support staff in this regard and to promote a multi-disciplinary approach to problem solving and decision-making within agreed parameters.

Sample session outline 9 – Improving decision-making processes within the team

Purpose: To improve decision-making processes within the team.

In relation to decision-making generally it is important that a team identifies its general philosophy or ground rules for decision-making – as a Facilitator you can assist the team to identify these factors. The key questions are:

- What are the hallmarks of good decision-making?
- As a team member how would you like to experience decision-making within the team?
- What consideration needs to be given to differentiating between clinical and business/operational decisions?

It is likely that team members will identify some or all of the following and you may wish to prompt some of these concepts:

- The decision-making process will be inclusive of all members of the team – due consideration will therefore be given to who needs to be involved

- It will be grounded in open and transparent sharing of information in a timely manner
- The process will be open to consultation and feedback to explore opportunities and concerns
- Adequate time will be given for consideration of issues within reason
- Respect for the fact that in some instances decisions will need to be made taking a balanced view of all the issues
- Acknowledgement of the reality of decision-making time pressures that will emerge
- Acknowledgement and exploration of the key factors that impact upon clinical decision-making – standards/codes of practice, ethics, implications of team-based decision-making within a clinical context, etc. These are all issues that require consideration at the level of the overarching Clinical Governance/Steering Group so that guidance can be provided to individual staff and teams

Steps to guide sound decision-making

Making decisions is part of all our daily functioning and much of our decision-making is happening naturally all the time. Therefore, the following is intended to guide significant decisions that are taken at team level in order to ensure that decision-making is guided by a sound process:

- Identify the issue and the context
- Clarify decisions to be taken
- Identify key stakeholders who need to be involved
- Establish decision-making criteria, i.e. criteria that relate to the principles of primary care services and/or the core purpose of the primary care service – see pg. 7 of this Guidance Document. It is also important to think about other criteria that might apply in specific clinical cases – these issues will emerge through dialogue within the teams
- Collect the information – what do we need to know, what do we already know, what is the knowledge gap?
- Assess the risks, the benefits and the impact
- Identify and analyse the options
- Evaluate/consider and prioritise the options
- Reach agreement and a process for sign off
- Implement the decision
- Monitor and evaluate the result/impact of the decision

Establishing clinical prioritisation processes – *appropriate for more established teams*

As teams develop they will need to consider how best to prioritise cases on a multi-disciplinary team basis. Some challenges team members will need to consider include the following:

- The challenge of embracing a social model of care as well as a medical/clinical model of care
- Embracing joined up working – consideration will need to be given to the impact for individuals of shared working/joint assessment/intervention – readiness and capacity of individuals to take this on board

- There will also be a need to consider uni-disciplinary obligations and ethics in advancing referrals that require a multi-disciplinary approach
- The development needs of staff to take on a broader agenda will also need to be attended to
- The team will need to consider different ways of working and use the data which is available on local community needs to inform their decision-making. What information is available on the needs of the local population? What information does the team have on the effectiveness of community based interventions?

Sample session outline 10 – Establishing team based-prioritisation processes

Purpose: To establish team-based prioritisation processes.

Some of the factors that teams need to consider in this regard include the following:

Factors to consider in prioritising cases

- Needs led prioritisation within the context of the broader social context of the client and his/her family. Clinical/medical needs may therefore not be the sole factor in determining priority of service delivery
- Cases that are considered 'complex' from a single discipline perspective should be discussed at team level as the need for engagement from other disciplines may only become apparent through team discussion
- Discuss among team members what would constitute an 'urgent case'
- Consider the national targets regarding developments within primary care – what are the implications for prioritisation within teams?

Some prompts

In line with the factors above, suggested prompts to assist discussion are outlined below to assist with decision-making:

1. Is there scope for multi-disciplinary involvement to enhance the service for the client/family?
2. Would joined up working assist the client/family in accessing the service and maintaining contact with the service over time?
3. Does the family and wider social context indicate the need for a joined up response - families that may find it difficult to engage in clinic based services?
4. Would the service be enhanced if the intervention addressed family and individual client needs collectively?
5. Are other family members in receipt of services from members of the team or are they engaged with mental health services, disability services, children and family services, etc?
6. Is there a balanced focus on both the health/clinical needs of the client and the social needs of client/family?
7. Is there evidence where parent intervention is more effective and/or where joint individual and group work is suggested?
8. Is there scope for an effective early intervention approach? Is there evidence that earlier intervention would increase the capacity of the client to benefit from the service?

9. What health promoting/health preventative approaches can be identified that are manageable for the team?
10. What evidence is there that a community based approach is more effective?
11. Would timely intervention prevent hospital admission and support clients in receiving services at home?
12. Would timely intervention facilitate smooth transfer from hospital to the home?
13. What 'at risk groups' do you particularly need to attend to?

Review/evaluation processes – appropriate for more established teams

It is important that a PCT takes time to evaluate how well it is doing in terms of its core purpose and objectives. This will assist team members to identify the areas that need to change or develop. As a Facilitator you may be asked to run a session with the team to evaluate or review its progress.

Guidance to assist you in running a session on evaluation is presented in *Improving Our Services: A Users' Guide for Managing Change in the Health Service Executive (2008:67)*.

Sample session outline 11 – Reviewing team functioning

Purpose: To review how well your team is functioning.

Prompt questions

- What did you set out to do, i.e. what was your agreed purpose and core objectives?
- How do you know you are doing a good job?
- Can you describe what you achieved in relation to your core objectives? Were there areas that you were unable to address – can you describe these and consider possible reasons why not?
- In relation to your team – what worked well that you could do more of?
- What didn't work that needs improvement?
- Are there activities that you believe you should stop doing?
- To what extent do you believe that the needs and interests of your key stakeholders have been achieved?
- What is the information from specific measures of team/service performance and outcomes telling you about the success of your PCT?
- What is the learning from risk assessments and any other quality/accreditation processes that you may have been engaged in telling you?
- Have you explored the possibilities for identifying service improvements within the context of the Integrated Quality, Safety and Risk Framework?
- What action needs to be taken based on the learning from the evaluation to improve the service you are delivering and to improve your overall team effectiveness?
- How will the learning from the evaluation be documented and communicated?

More in-depth session on reviewing a PCT in line with its core purpose/principles

It is important that teams review their progress in line with their stated purpose and core objectives. The following are some suggested key proofs that can be developed and/or refined as appropriate. It is important to keep in mind the evolving nature of primary care services and the hope that over time it will be possible to make progress on all of the 'proofs' outlined below. From a timing perspective you need to consider readiness within teams to introduce the 'proofs' noted below. They are probably more appropriate to a team that is established for some time – however it is important that the overarching Clinical Governance/Steering Group and the Chairpersons/Co-ordinators of teams keep these principles at the fore front of their decision-making processes.

Sample session outline 12 – In-depth review of PCT performance

Purpose: To carry out a more in-depth review of the performance of a PCT in line with its core purpose/principles.

Whole population approach that is responsive to the changing needs of families and the local community, and which is based on assessed needs for a defined population

- Are decisions informed by the identified needs of the population and by evidence of best practice?
- What evidence is there that the team/network is beginning to target interventions that embrace the broader needs of the population/local community?
- How effectively is information regarding demographics and other information on patterns of health status being used?

Co-ordinated multi-disciplinary team/service response with the PCT acting as the main hub of service delivery

- What evidence is there of a multi-disciplinary team response to meet client needs?
- What evidence is there that primary care services are acting as the main hub for service delivery for all clients?
- Are you developing processes and protocols that promote a joint approach to meeting client needs?

Teams will develop shared care arrangements as appropriate with other services both within the HSE and the voluntary and community sector in order to support a co-ordinated approach along the client pathway.

- What steps have been taken to explore the linkages between primary care services and specialist/care group services?
- How can these linkages be strengthened and developed?
- What additional considerations need to be taken into account in improving linkages with the community sector?

A holistic approach that maintains a client/family/community focus over the whole lifecycle – promoting an appropriate and balanced medical and social care model of service delivery.

- Are decisions focused on the holistic needs of the client/service user and their family across the whole life cycle?

- How are dilemmas within individual disciplines in this regard being resolved, i.e. where an overall service priority or priority in another area overrides the capacity of some disciplines to provide a timely holistic team response to individual clients?
- Do decisions balance the health and social care needs of individuals and their families?

Services located in the local community with a focus on continuity of care and easy access

A service that is accessible and responsive to locally assessed need and is grounded in local community knowledge

- What evidence is there that local community knowledge is being used to shape decision-making within teams/services?
- What evidence is there that clients move between services with greater ease and that continuity of care is being fostered?

Emphasis to be placed on health promotion/early intervention and prevention

- Has the PCT/service been able to prioritise dedicated time for early intervention and prevention programmes?
- Is there evidence that early intervention and prevention work has become inherent in everyday practice for all disciplines?
- What opportunities are there to develop improved linkages with health promotion staff and develop targeted initiatives?

A service that makes the most effective use of all resources and facilitates resource allocation based on client need

- Are we utilising the resources we have in the best way possible?
- Are we continuing to examine ways of working to target efficiencies?

A service that is delivered through PCTs and Networks, and that actively develops linkages with the acute hospital sector, other teams and services and wider community groups and agencies

- What steps have been taken to improve linkages between services from a client perspective?
- How effective are discharge processes from the acute hospitals and ongoing delivery of services within the community for patients?
- Is there evidence that the enhanced delivery of primary care services has reduced the need for hospital admissions?

Relationships: Attending to inter-personal and intra-team relationships

The importance of inter-personal relationships between members of the team and with other teams is the most critical factor for effective team working. The individual styles of team members will impact on how well the team is working at different stages in its development.

Within the context of Network based/specialist services the nature of the relationship between teams is critical – clients may be in receipt of services from members of a PCT and care may also be shared with members of Network based services including the acute sector, disability services, mental health services and so on. Some team members may also move between PCTs and this also poses challenges for individuals in terms of flexibility and adaptability to different team cultures. The importance of relationships between members of the team and service users is also a factor to be considered.

In some instances issues that emerge between team members may be tracked back to a lack of overall shared agreement on the core purpose of the team, lack of clarity regarding roles and the contribution of individual disciplines, poorly defined processes for communication or decision-making. Therefore, attending to the upper end of the Model for Effective Team Working as outlined earlier on pg. 28 will assist in addressing some of the issues that may cause inter-personal difficulties. Basic advice on attending to face-to-face communication processes will create a solid platform for good relationships. Clarity also regarding the role of the overarching Clinical Governance/Steering Group will assist in providing the supports necessary to assist teams overall to function within a well defined framework.

Some of the team development modules outlined in Phase 3 (see pg. 54) may also be helpful in assisting team members to understand the impact of individual styles on working relationships within and between teams, for example Belbin Team Role Inventory and Myers-Briggs Type Indicator (MBTI). Understanding stages of group development may also assist some teams to understand and explore relationships within teams as outlined below.

Possible methodology for understanding group development

Teams progress through different stages of development and at different paces. In many respects teams develop through resolving dilemmas and learning how to work together themselves. At times however a team may become 'stuck' or may begin to experience inherent differences or conflict. Some teams may simply request an opportunity to explore where they are at in terms of team development. It may be helpful therefore for some teams to outline the stages of team development and assist team members to understand what may be happening at these different stages.

Stages of Team Development

The **Forming – Storming – Norming – Performing** model of group development was first proposed by *Bruce Tuckman (1965)*, who maintained that these phases are all necessary and inevitable in order for a team to grow, to face up to challenges, to tackle problems, to find solutions, to plan work and to deliver results. It is included in this Guidance Document as it appears to be one of the reference points that teams are familiar with.

FORMING

In the Forming stage, team members are getting to know one another and getting comfortable with one another. Members will naturally try to understand their own roles, the roles of the other team members and their purpose in the group. This is entirely natural and to be expected. People may be unsure and nervous.

Characteristics of Forming

Look for the following behaviours in the Forming stage:

- Members trying to define the task
- Conceptual discussions as people try to express who they are
- Discussions about what information needs to be gathered

How to address the Forming stage

It is important to provide team members with opportunities to get to know one another. Make sure the purpose of the team and expected tasks are clearly defined. It is also important to share the expectations that management and/or the overarching Clinical Governance/Steering Group has of the team. Clarity of purpose and roles is highlighted as a significant enabler to effective team working in the Model for Effective Team Working (see pg. 28). It is important that team members are given time to get to know one another. Team members may want however to move on to addressing their core tasks – within many PCTs the motivation of staff to commence clinical discussion and progress joint care is always evident.

STORMING

The challenges of working together become more apparent as time progresses. Once the team works together for a while they may enter the Storming stage. Politeness begins to wear off and dissension can occur over the basic purpose of the team and operating processes. Control often becomes the primary issue. Who is going to decide what? Disagreements can be either very obvious or subtle.

Storming can be the most difficult stage for a team to weather, but if the Forming stage is managed Storming can occur with composure. When team members begin to trust one another enough to air differences, this signals readiness to work things out.

Characteristics of Storming

Look for the following behaviours in the Storming stage:

- Members begin to show their true styles
- A growing impatience will surface over lack of progress
- Members will get into one another's territory, causing irritation over boundaries
- General disagreement over process, task and overall purpose of the team

How to address the Storming stage

Don't ignore the Storming stage as this is where most learning can occur. Acknowledge it with the team as a natural developmental step. Facilitators should surface the conflicts and assist the team to address them. This is a good time to review ground rules, revisit the purpose and related administrative/process matters for the team.

NORMING

Once a team recognises their differences and has dealt with them, they move to Norming, the stage when they ask, 'How are we going to accomplish our work?' Beyond the politeness and nervousness of Forming and past the issues and concerns of Storming, teams will want to review how they are functioning. As team members learn to work out their differences and conflicts are reduced, they will have more time and energy to focus on their purpose.

Characteristics of Norming

Look for the following behaviours in the Norming stage:

- Ground rules and formal processes that may have been overlooked in the beginning are now taken more seriously
- There is overall clarity regarding purpose and shared objectives
- The team will want to discuss items more; less time will be spent on idea generation and more on decision-making
- Members will want to limit agenda items to focus on specific topics
- Subgroups may be formed to move along faster
- Conflicts are addressed and resolved and/or managed

How to address the Norming stage

At this stage, the team has successfully embedded core processes as outlined in the Model for Effective Team Working (see pg. 28) – referral, prioritisation, communication, decision-making processes, etc. Tasks will take on new significance as the team will want to accomplish its purpose with an openness perhaps to consolidate key aspects of their role.

PERFORMING

In this particular description of team development, performing is described as the final stage.

Performing teams are described as effective, problem-solving units that can reach solutions quickly and often preempt and address issues before they become problems.

Characteristics of Performing

A team in the performing stage will:

- Be pro-active and not necessarily wait for direction from management
- Demonstrate loyalty to the group and respect individual dissension and disagreement

How to address the Performing stage

Teams at the performing level are generally self-regulating. However, should the team dynamics change, for example a team member leaves and a new member joins the team the team can again revisit the Forming, Storming and Norming stages.

Sample session outline 13 – Increasing understanding of group

Purpose: To increase team member's understanding of group development.

How to use the above information in a session

The stages of group development as outlined above may assist a team to understand what is going on within their team dynamics. It is important to indicate that the stages as outlined above are not linear and teams will not go through all the stages in a structured predictable way. Changes within the team such as someone leaving, a new person joining or other external changes will naturally impact upon the overall balance within the team. The concepts of Forming, Storming, Norming and Performing however provide a shared language or reference point that will assist discussion and will also provide opportunities for staff to name issues that are causing tension or simply to review where they think they are at.

In relation to each stage you may therefore wish to explore with the team members the behaviours that are typical at each stage as outlined above and ask the following questions:

- What stage do you think your team is at?
- What behaviours are team members displaying?
- Why do you think people are displaying these behaviours?
- What is this telling you about the team?
- What do you think will assist your team to address the team issues that are emerging and progress to the next stage of development?
- Is there a need for the Team Co-ordinator/Chairperson to take up a different role? What supports do they need in this regard?
- Having reached a better understanding of what is happening within the team – what does the team need to do now?

PHASE 3: SPECIFIC TEAM DEVELOPMENT MODULES

This section outlines specific team development modules which are available to support teams.

When a team is well established it may be appropriate to consider what form of team diagnostic or needs assessment might be helpful to indicate their ongoing development needs. The Facilitator/Heads of Discipline and the TDO in liaison with the Chairperson/Co-ordinator and team members can consider the options available. Based on the outcome of this analysis it may be appropriate to offer specific development interventions as noted below:

- Managing meetings
- Conflict management
- Decision-making
- Understanding group dynamics
- Stages of team development
- Self-awareness assessment tools, e.g. Belbin Team Role Inventory and Myers-Briggs Type Indicator (MBTI)
- Developing communication processes
- Team-Based Performance Management
- Client focus/customer service
- Facilitation/chairing skills

A programme could be developed in modular format and delivered in ways best suited to individual teams, e.g. full days, two hour sessions, etc. As teams will differ in their level of readiness, this approach allows for flexibility in content and delivery methods and can meet local needs. The Performance and Development Team has outlined the training interventions available within Dublin North East in the table below.

Training Intervention	Diagnostics
Induction (Checklist) <ul style="list-style-type: none"> History and transformation of health services in Ireland HSE Organisation Structure HSE Mission and Strategies Understanding of key functions within HSE 	
Performance Planning and Review (PPR) Team-Based Performance Management (TBPM) <ul style="list-style-type: none"> Understanding concepts of PPR/TBPM Set SMART goals and realistic measures Role of Team Leader vs Team Member Understanding of team development Giving and receiving of constructive feedback 	Team Diagnostic SWOT Analysis Force Field Analysis
Personal Development Planning (PDP) <ul style="list-style-type: none"> Identification of preferred learning style Team Role Preference Work/Life Balance Goal Setting and Career Planning 	Learning Styles Questionnaire (Honey and Mumford)
Management Development Programme Modules <ul style="list-style-type: none"> Teambuilding Motivation Customer Care Effective Meetings Time Management Communication Managing Conflict Inter-cultural Awareness Figure out Finance Risk Management Health and Safety 	Belbin Team Role Inventory (Dr. Meredith Belbin) Conflict Mode Instrument (Thomas Kilman)
General Development Programmes <ul style="list-style-type: none"> Presentation Skills Coaching Skills Assertiveness Clerical Admin Development Programme 	
Understanding and tolerating difference among personality types using MBTI <ul style="list-style-type: none"> Self-Awareness Communication Decision-Making Conflict Change 	MBTI (Myers Briggs Type Indicator)
People Management, The Legal Framework <ul style="list-style-type: none"> Recruitment Managing Performance Dignity at Work Equality Attendance Management Grievance Trust in Care 	
Prepared by the Performance and Development (P&D) Team – Dublin North East (February 2010) For further information on any of the above training interventions, please contact the P&D Team at 041-6871430.	

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