Effectiveness of Multi-Professional Team Working (MPTW) in Mental Health Care

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Glossary of terms/abbreviations

AO	Assertive Outreach
ATPI	Aston Team Performance Inventory
BME	Black and minority ethnic
CLRN	Comprehensive Local Research Network
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution & Home Treatment Team
CSIP	Care Services Improvement Partnership
CSO	Clinical Studies Officer
CSP	Clinical Studies Portfolio
EIP	Early Intervention in Psychosis
ESRC	Economic and Social Research Council
HR/HRM	Human Resources (Management)
IRAS	Integrated Research Application System
MHC	Mental Health Care
MHRN	Mental Health Research Network
MPTW	Multi-Professional Team Working
NIHR	National Institute for Health Research
NIMHE	(former) National Institute for Mental Health in England
NHS	National Health Service
PCT	Primary Care Trust
PIC	Participant Identification Centre
R&D	Research & Development
R&R	Rehabilitation and Recovery
REC	Research Ethics Committee
SM	Substance Misuse

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The authors are listed in alphabetical order, other than Michael West who is listed first as the Principal Investigator. The contribution of each author is as follows.

Michael West was Principal Investigator, responsible for overall study design, and writing significant sections of final report. Beverly Alimo-Metcalfe contributed to the study design and wrote sections on leadership. Jeremy Dawson contributed to all aspects of study design, analysed the quantitative data, and wrote several sections of the report. Walid El Ansari contributed to study design and formation of CMHT effectiveness scale, wrote the sections on resources and contributed to interpretation of results. Jon Glasby contributed to the study design and interpretation of results. Gillian Hardy contributed to the study design and interpretation of results. Ginny Hartley undertook a large part of the stage 3 data collection and analysis and wrote the findings for this stage. Joanne Lyubovnikova had a significant role in design and data collection for stages 1 and 2, and contributed to formation of CMHT effectiveness scale. Hugh Middleton contributed to the study design and formation of the CMHT effectiveness scale, wrote sections on organisational context and contributed to interpretation of results. Paul Naylor led the data collection and contributed to the design for all stages, contributed to the formation of the CMHT effectiveness scale and design of stage 3, and wrote several sections of report. Steve Onyett contributed to the study design, wrote the section on implications and recommendations, and contributed to interpretation of results. Andreas Richter contributed to the study design, wrote sections on inter-team working and contributed to the interpretation of results.

Executive Summary

Background

Multi-professional team working (MPTW) has increasingly become an important feature of the organisation of work in all sectors. When decisions and actions made by multi-professional teams are based on the perspectives of all members they are generally of higher quality than those made by single discipline teams and individuals acting alone. While the potential value of multi-professional teams may be clear, there is evidence that organisations often have difficulty in realising the benefits. In particular, little is known about the factors influencing the effectiveness of MPTW in the context of adult mental health care in the community.

Aims

The overall aim of this research was to identify the principal factors that ensure MPTW is effective in delivering and improving mental health care for service users. The research explored the following factors: team task design; team effort and skills; resources; organisational supports; team processes including objectives, reflexivity, decision making, task focus and conflict; leadership processes; and outputs comprising team member satisfaction, inter-team working effectiveness, innovation and overall team effectiveness.

Specifically, this research aimed:

1. To identify facilitators and inhibitors of effective MPTW, including leadership, team processes, organisational support and context-specific factors including structures and processes driving and guiding the work of CMHTs.

2. To develop and test diagnostic tools for measuring MPTW processes and effectiveness and the organisational processes and supports for MPTW. Effectiveness is here defined as the extent to which teams fulfil or exceed the requirements of their key stakeholders, including the team members themselves, and particularly focused on meeting the needs of service users.

3. To provide practical guidelines that can be easily adapted to develop MPTW and thus make a positive difference to team work in adult mental health care, and thereby to the quality of care for service users.

Methods

This was a three stage project. The aim of Stage 1 was to establish the characteristics of MPTW effectiveness from the perspectives of key stakeholders (service providers, users and carers) for use in a quantitative questionnaire

measure of MPTW effectiveness in CMHTs. Stage 2 involved a large scale survey (incorporating the Stage 1 measure) of 135 teams in 11 NHS Trusts examining team inputs, processes, leadership, organisational support, resources and team effectiveness. Stage 3 involved in-depth ethnographic studies of 19 of the teams involved in Stage 2.

Results

Stage 1
Working with stakeholder groups, including service users, the research team developed a measure of MPTW effectiveness. The CMHT Effectiveness Measures is a 20-item questionnaire that assesses seven key domains of effectiveness identified in Stage 1:

- improved service user well-being,
- creative problem solving,
- continuous care,
- inter-team working,
- respect between professionals,
- responsiveness to carers, and
- therapeutic relationships with service users.

Stage 2
The use of the 100 item Aston Team Performance Inventory (ATPI) and 20 item CMHT effectiveness scale across 135 teams revealed that CMHTs generally reported lower levels of resources, organisational support, achievement of goals and managerial praise for performance than other NHS teams. CMHTs reported higher levels of task focus, participation in decision making, constructive debate, focus on quality and discussion of errors. There were relatively high levels of trust, safety and support and relatively good communication.

Early Intervention teams appeared to be the best functioning of the teams in the sample and Generic CMHTs the worst.

Key predictors of CMHT effectiveness were practical support for creative and innovative approaches to providing care for service users; team participation in decision making; regularity of meeting; and trust, safety and support among team members. Team leadership was also a strong predictor of effectiveness. Having the right mix of skills and a high level of effort was characteristic of effective teams, as was having a well-designed team task (autonomy, task relevance, a complete task, feedback on performance).

For older adult CMHTs, the resources available was the most important predictor of effectiveness. For all team types, organisational support was an important predictor of inter-team working. An absence of conflict within teams was another very important factor in effective team working.

Stage 3
The ethnographic studies and observation of team meetings revealed that shared decision making was a genuine feature of many CMHTs, but it depended

on team type and leadership. The quality of team processes was variable but generally positive and supportive climates were typical of most teams.

Features of effective teams were the resources available to the team, particularly staff availability. The most effective teams had the time to plan care, the right mix of professionals, and positive inter-professional attitudes. Less effective teams were often hampered by targets, bureaucracy, staff turnover, staff shortages and inflexible ways of working.

Positive attitudes to change and honest, open, trusting team relationships were characteristic of the most effective teams. This climate extended to carers and service users with such teams active in promoting carer involvement. The most effective teams also sought out ideas for new and improved ways of providing high quality care. Their inclusiveness extended to other teams and agencies with which they had to interact to ensure high quality care. Leaders played a crucial role in this.

Many of these findings are not new in relation to our knowledge of teamwork generally and in healthcare in particular, but how they manifest in the context of mental health care provision is. They have significance particularly in their implications for practice. We describe recommendations below in priority order.

1. Clarify purpose and function of CMHTs.

Clear specification of purpose and team objectives is a cornerstone for good team design. When these are clear, team members can shape and develop clear roles and ways of working interdependently and effectively. Where local needs assessment reveals a need for a more "generic" service, particular attention will need to be given to clarifying team objectives.

2. Provide good leadership

Good leaders continually clarify vision, purpose and team objectives and help team members clarify their individual roles and objectives. They also manage the organizational context; negotiate for appropriate resources; lead inter-team cooperation and manage change effectively. They have an engaging leadership style; ensure time and space for away days and reflection space; manage meetings effectively; and manage intra and inter-team conflict; they involve users and their supports; and value diversity within teams. The findings reveal the central importance of honest, trusting and respectful relationships at all levels: between users and team members, between team members, between team members and their managers, and between team members from different teams.

3. Actively manage team composition and processes.

Team members' knowledge, skills, experience and, as importantly, values and attitudes, must fit well with the demands of the team task. Team processes should also be designed to ensure that practitioners receive constructive and useful feedback, through clinical review meetings, peer support, supervision and appraisal. Diversity within teams is an asset where there is a norm of positive

attitudes to the value of diversity for team innovation and effectiveness. Of most importance is ensuring information on outcomes and experience of end users continuously informs team improvement.

4. Promote inter-team working.

This involves having structures and processes in place that reduce inter-team conflict, as well as protocols for transfer to other teams that promote cooperation. Organizations must encourage inter-team meetings, and promote strong, positive identification with the wider aims of the organisations.

5. Ensure reflection and adaptation

Teams require opportunities for reflection in order to develop their skills, improve their processes and continuously improve their productivity and the quality of care they provide. They should have sufficient autonomy to innovate within safe boundaries. Leaders should help teams to create space for reflection on team objectives and processes. Such time must be defended and factored into considerations of team capacity to meet local demand.

6. Hold effective team meetings

We recommend that all mental health teams ensure their meetings are effectively chaired and structured around a clear written agenda tightly linked to team objectives. Service for users should be the central theme of most meetings. The usefulness and effectiveness of meetings should be regularly reviewed.

Conclusions

It was clear throughout this research that those who work in CMHTs are both compassionate and dedicated in their commitment to working with service users to deliver high quality care. The strategy and supports provided by the Trust within which teams work plays an important part therefore in the teams' ability to deliver and continuously improve care for service users. Leadership in this domain, as in all others in health care, is critical. Investing in developing good leadership in health care teams is important if CMHTs are to achieve their potential. Many teams are working in very challenging and, at times, dispiriting situations. With targeted interventions, indicated by the findings from this report, much can be done to support them in their work, thereby improving care for service users.

The Report

1   Chapter 1: Background

Chapter Summary

This chapter provides the background for and aims of the three related and sequential studies of multi-professional team working (MPTW) in mental health care which underpin this research programme. Each stage is presented in consecutive chapters (2, 3 and 4) of this report.

1.1 Introduction

Over the last 20 years there has been a substantial increase in the use of multi-disciplinary teams in the organisation of work across a wide range of work contexts [1-3]. Examples of such teams include "product development teams, cross functional teams, brainstorming groups, and management teams" [4]. This is premised on the belief that because the decisions and actions made by multi-disciplinary teams are based on the perspectives of all members, they will be better than those made by single discipline teams and individuals acting alone. While the potential of multi-disciplinary teams may be clear, there is evidence that organisations often have difficulty in realising this potential [3, 5-8]. Recently, research has focussed on the conditions under which team diversity leads to improved performance. As a result of these efforts, we now know, for example, that expertise diversity tends to lead to improved performance in non-routine task environments [6, 7] and that the quality of information sharing communication is associated with team performance [4].

The issue of MPTW in mental health care is topical in the UK with the introduction of the Health and Social Care Bill on 19th January 2011. One of the main criticisms of this Bill was that the proposals (as initially expressed) seemed to place significant emphasis on promoting competition (rather than co-operation and collaboration). For example, Monitor's role was to change to that of an economic regulator with an explicit duty to promote competition. This was criticised by a number of commentators, who argued that people with complex needs (and mental health is a good example) need an integrated approach to their care, involving multiple health care disciplines and possibly health and social care agencies. An ongoing dilemma has therefore been how to promote competition and collaboration at the same time, and how to strike an appropriate balance. This was addressed by the NHS Future Forum, set up by government to advise on the Bill (see http://healthandcare.dh.gov.uk/category/conversations/future-forum/). Based on its consultations with service users[1] and professionals, the Forum produced a

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[1] The label that is used to describe receivers of health services is contested by professionals, published authors, the receivers of services and carers (see, for example, Simmons, Hawley, Gale, & Sivakumaran, 2010). Commonly used terms include patient, service user and client, and much less frequently, survivor. In this

first report that led to significant changes in the Bill - and one of its work streams focused on the issue of choice and competition. It has now been asked to continue for a second phase with one work stream providing independent advice on how to ensure that "the modernisation programme leads to better integration of services around people's needs". At a time when policy makers are debating these issues, it is good that we can offer detailed research evidence on MPTW and collaboration in mental health care and the factors influencing the effectiveness of teams providing care for patients in this sector.

The difficulties of establishing effective MPTW in health and social care are also well recognised. A recent ESRC-funded meta-analysis of the relationship between team working and organisational performance in health and non-healthcare settings reaffirms that there is a positive and significant association [9]. However, reviews also reveal considerable variation in the quality of MPTW and a need to identify the factors that determine these differences in team effectiveness. Although 92% of NHS staff (93% in mental health Trusts) report working in teams, only 42% work in well-structured teams: those where the members say they have clear team objectives, interdependent working, and regular meetings to discuss effectiveness [10]. This means that 50% of all NHS staff work in poorly-structured, or "pseudo" teams, whose members report high levels of errors, accidents and poor staff well-being [11].

Recent research shows that one of the key characteristics of organisations providing high-quality mental healthcare is effective multi-disciplinary working and training [12]. Following publication of the UK Government's *National Service Framework for Mental Health* (NSF-MH) [13] and its *Mental Health Policy Implementation Guide* (MH-PIG), NHS mental health services for adults have been obliged to adopt a pattern of provision based upon distinct teams providing for each of several client groups and these are now represented in virtually all mental health Trusts in England. Previously, provision was mostly provided by generic CMHTs (now sometimes referred to as Primary Care Liaison teams), which served the needs of all MH service users within their localities.

Two major components of the NSF-MH and MH-PIG requirements were "the creation of AOTs (Assertive Outreach teams) for 'difficult to engage' people living in the community and Crisis Resolution and Home Treatment teams (CRHTs) to work as an alternative to hospital admission for individuals experiencing acute crises in their mental health" [14]. Other types of CMHT that are commonly found in NHS Trusts include those associated with Early Intervention (EI), Older Adults (OA), Substance Misuse (SM), and Rehabilitation and Recovery (R&R).

EI teams usually work with people between 14 and 35 years who are either at risk of or are currently experiencing a first episode of psychosis. This kind of service has been set up on the basis of robust clinical effectiveness which shows that the longer an episode of psychosis goes untreated, the poorer the outlook for the service user. Indeed, there is strong evidence showing that EI (compared

to standard services) reduces hospital stays, relapses and suicide rates [15]. In many NHS Trusts Older Adult (OA) services are provided for people of 65 years and older many of whom suffer from depression or dementia and who often have comorbid physical disabilities and impairments.

In relation to Substance Misuse (SM) teams, a recent prevalence study of CMHT service users [16] found that: "44% ... reported a past-year problem of drug and/or harmful alcohol use; 75% ... of drug service and 85% of alcohol service patients ... had a past-year psychiatric disorder" (p. 304). The authors concluded that "most comorbidity patients ... are not identified by services and receive no specialist intervention" (p. 304). This may be because mental health services and substance misuse services are often run by different teams in the same locality of a Trust. The consequence is that service users can be "bounced" between services and so do not receive the care that they need (Mental Health Care, accessed 5th September 2011 at: www.mentalhealthcare.org.uk/psychosis__drugs_and_alcohol). In many Trusts there are also Rehabilitation and Recovery (R&R) teams. Theoretically at least, these teams undertake a number of tasks including "offering care co-ordination for patients being resettled from inpatient rehabilitation units into less dependent settings ... and ... provide expert advice on the development of complex packages of community care and support as an alternative to residential and nursing home care ..." [17]. Finally, there still exist many generic Community Mental Health Teams (CMHTs), presumably in localities where population densities are so low that providing the full range of functional teams is not viable. However, in some Trusts the term CMHT is now also being used to refer to an amalgamation of teams brought about in response to "economic" pressures. Teams of all types are, at minimum, composed of a psychiatrist, some community psychiatric nurses (CPNs), some "non-qualified" support workers and an administrator. However, many teams also have at least access to a clinical psychologist, a social worker, an occupational therapist, and very rarely, a counsellor or psychotherapist and hence our use of the term "MPTW in mental health care". The psychiatrist has overall responsibility for the work of the team although its day-to-day management is usually the responsibility of another clinical team member. Whatever the team types and whatever their staffing compositions, the goal of all mental health services should be service user "recovery" [18], that is, "the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness ..." [19].

Vital to enabling recovery is an understanding of the factors that ensure the effectiveness of mental health care teams in providing care and support for service users and their carers. Previous research suggests that the broad input and process factors influencing healthcare team performance are common across settings [20] and stakeholders [21]. A series of healthcare studies [22] has shown that the team processes predicting effectiveness (particularly establishing clear team objectives and regularly reviewing performance) are stable across teams in breast cancer care, primary care, acute sector teams and community mental health [22, 23].

Another key factor is collaboration across professional and organisational boundaries. There is a longstanding history of need for effective inter-agency and inter-professional team working in mental health care to ensure service

users receive the best possible care [24-29]. And leadership matters too. An earlier SDO-funded study involving mental health CRHTs found evidence of a consistent cause-effect relationship between an engaging style of leadership and the productivity of teams [30, 31]. Case study data identified specific leadership behaviours associated with successful teams [30]. In this study, as in other research [32-35], influential leadership behaviours included leadership capabilities, that is, acting in a competent way, engaging with staff, and visionary leadership. Also important were coaching and/or mentoring.

Theory and research in MPTW suggest a broad range of inputs and processes that are relevant to team effectiveness. Four processes, however, have been identified as being particularly significant, the first being *diversity*. Professional diversity is associated with higher levels of team conflict but also higher levels of innovation when team processes are managed effectively [36]. Conversely, the literature on inter-agency collaboration suggests that the desire to create genuine 'synergy' can be undermined. If managers become too concerned with maintaining peaceful partnerships, constructive controversy that could produce radical innovation in service user care may be stifled [37]. Problems of diversity are compounded when team members work for different employers, and when differences coincide with demographic or professional differences between team members [38]. Understanding the parts played by relationships between professional groups in determining the success of MPTW is an important feature of the NIMHE's "Mental Health: New Ways of Working" programme 2007 which was aimed at all mental health staff and looked at ways in which they can work more flexibly within teams. Importantly, this report promotes a model where "distributed responsibility" is shared amongst team members and is not simply delegated by a single professional such as the consultant psychiatrist.

Second, there is growing evidence that *integration* between teams in delivering services may be even more important than intra-team processes [9]. Key players affecting the integration of different healthcare teams are team "boundary spanners", those individuals most involved in task-related interactions between teams, frequently the team leaders. Effective inter-team working is also crucial from the perspective of users and carers concerned with continuity and effective communication. Onyett et al.'s [30] national survey of crisis resolution teams found, for example, that team effectiveness was compromised by capacity problems in other parts of the local service system, and particularly among generic CMHTs. Research suggests that factors hindering effective inter-team collaboration include structural variables such as intergroup competition [39], along with attitudinal variables such as hostile intergroup attitudes [40]. More recent concepts found to be relevant include team leaders' identification with the overall health care organization, along with frequent task-related contact between teams [9]. Further, team leaders' negotiation style influences the way in which intergroup competition for enhanced healthcare team effectiveness is managed [41]. And lastly, frequency and quality of contact between teams under co-operative conditions assumes a central role in creating effective relationships between teams [42]. A particular issue of relevance to inter-team working in MH care raised by practitioners is inconsistency in the principles, policies, and practices of the different agencies such as health services, police and social services that have a duty of care in relation to service users.

Third, research on MPTW within healthcare and other settings suggests that *reflexivity* (the extent to which teams meet to review and modify objectives, strategies and processes in service of their overall goal) is a powerful predictor of effectiveness and innovation [43]. However, many teams are so consumed by the task or so resistant to change that they fail to review and revise their approaches, continuing to expend energies in directions that are sub-optimal for service user care.

Finally, the effectiveness of teams is best understood within their organisational context [44] and levers such as commissioning capacity and intention and local partnership behaviours at a macro level [45]. The local context is and will continue to be a key factor in shaping attempts to develop MPTW, especially given recent DH guidance in "No health without mental health" [46], which is less prescriptive than earlier guidance about team design. Alimo-Metcalfe et al. [30] identified a range of contextual factors that affect the performance of multi-professional teams while Glasby [47] has shown the importance of understanding the individual, organisational and structural aspects of MPTW (and the ways in which these interact). West and colleagues have focused on the effects on MPTW of organisational climate and HRM practices in various studies [48-52].

1.2 Aims and Objectives

The overall aims of this research were to identify the principal factors that ensure MPTW is effective in delivering healthcare and improving health outcomes and team effectiveness and thereby to improve service user care. The research has been built around an established input-process-output model of team working, and it has explored input variables such as task design, team effort and skills, team resources, organisational supports; team processes including clarifying objectives, reflexivity, decision making, conflict; leadership processes; and outputs such as team member satisfaction, intra- team effectiveness, inter-team working effectiveness and innovation.

In particular the aims were:

1. To identify broader contextual facilitators and inhibitors of MPTW, including leadership, organisational culture, support for team working and context-specific factors including resources, structures and processes (clinical, professional, and geographical). These factors are important because improvements in one part of a local system can sometimes be at the expense of others, creating weakened relationships and instability. By taking local whole systems as our focus (looking at inter- as well as intra-team relationships) we have aimed to provide practical knowledge which should help to create substantial and sustainable differences throughout health and social care settings.

2. To adapt and develop diagnostic tools for measuring MPTW processes and effectiveness and the critical organisational processes and supports for MPTW, that can then be used across diverse health and social care contexts. Our objectives included developing methods for measuring MPTW effectiveness

across diverse contexts with a view to providing practical means of developing robust measures of effectiveness across all health and social care settings.

3. To encourage the development of improvement interventions, based on the research findings, we aimed to identify those that can be used in the research sites and beyond. We aimed to provide practical knowledge that can be readily adapted to develop MPTW throughout health and social care settings, and thus make a substantial and sustainable difference to the ways in which health care is delivered in the UK. This includes identifying the managerial tools and processes that will enable better integration of the work of health and social care professionals.

1.3 Study background

This was a three stage sequential project[2]. The aim of Stage 1 was to establish the characteristics of MPTW effectiveness from the perspectives of key stakeholders - service providers, users and carers. This stage aimed to construct a quantitative measure (questionnaire) of MPTW effectiveness in CMHTs with the requirement that it would be suitable for adding to a well-validated instrument – the Aston Team Performance Inventory (ATPI) [53], which was used in Stage 2 of the project. Stage 3 involved in-depth ethnographic studies of a small sample of the teams involved in Stage 2.

Each of the sequential Stages 1-3 is now presented in detail in Chapters 2, 3 and 4.

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[2] Initially there was to be a fourth stage to the project, in which existing interventions of team working in community mental health settings were to be evaluated. However, due to significant problems encountered in the research governance process, there was insufficient time for this and the fourth stage was dropped at the suggestion of the NIHR SDO programme. This inevitably affected the extent to which the third aim, as listed above, could be addressed in full

2 Chapter 2: Stage 1: Gathering stakeholder perspectives on MPTW effectiveness

Chapter Summary

This chapter describes the first stage of the study, which used a series of workshops to create a measure of effectiveness for community-based adult mental health teams. Three phases of workshops, involving service providers, service users and carers, were used to identify key domains of team effectiveness, to derive questions that could be used to measure these, and to refine and weight the domains. This produced a 20-item measurement tool that was then used in Stage 2 of the research.

2.1 Methods

2.1.1 Background

We used a formative evaluative approach to develop a questionnaire measure of MPTW effectiveness based on the Productivity Measurement and Enhancement System (ProMES) [54]. ProMES requires that effectiveness criteria are firstly established in group discussions involving all major stakeholder groups. These variables are then psychologically scaled to form a common effectiveness measure that can be used to compare, monitor and improve performance and provide feedback. The system is then used to set objectives, develop indicators, monitor and improve performance and give feedback to the team. Pritchard [54] presents a detailed description of how ProMES is done. ProMES is a formal, stepwise process that identifies team (or organizational) objectives, develops a measurement system to assess team performance against those objectives, and produces a feedback system giving team members and managers clear and accurate information on how well the team is performing. The feedback system is designed to improve productivity. A detailed review of the theoretical background, mechanics and research evidence related to ProMES is provided by Pritchard et al.[55].

The approach enables development of contextually specific measures of effectiveness that have high face validity for stakeholders, in our case, members of CMHTs and their service users and carers. Typically, the method requires the co-operation of major stakeholder representatives in a series of focussed workshops. We adapted the methods to develop an effectiveness measure of MPTW in two ways. Following Pritchard (1990), the first step of ProMES implementation is the formation of a design team composed of people from the target unit (i.e. members of CMHTS, their users and carers). This typically includes facilitators, supervisors, and organizational members. However, we

adapted this method to also include service users and carers in the design team. This adaption was crucial in order to meet our research objectives, ensuring that the CMHT effectiveness measure ultimately developed incorporated the perspectives of service users and carers, and therefore has relevance and value to all major stakeholder groups, not just service providers.

A second way in which we adapted the ProMES methodology was to allow flux in membership of the design team. Largely for practical reasons, it was not possible to involve the same participants in all workshop phases. Many service providers could only attend one or two of the workshops, and therefore were not able to actively participate in the entire process from beginning to end. For this reason, we began each workshop with a debriefing session, informing participants about the methodology and results of previous phases, and providing copies of all summary reports for their reference. Although ProMES suggests that the design team to remain constant, we believe that this flux in membership enhanced the reliability and validity of the results, as it involved a greater variety of stakeholders from different occupational groups, Mental Health Trusts and geographical regions throughout the process. Further discussion of the application of the ProMES methodology is discussed under the respective sections below.

The aim of developing a single measure that can be applied across all types of teams in the study was obviously challenging, and necessarily would produce a measure that is broad rather than specific in its nature, and therefore reflects a somewhat limited operationalisation of the concept of effectiveness. Nevertheless an important feature of this stage of the research was to examine the extent to which consensus existed between professionals, service users and carers from different parts of the service.

2.1.2 Sampling of NHS Trusts for project stages 1 & 2

Fourteen Trusts in England were selected for participation in these stages of the project. Trusts volunteered for participation based on information submitted by the Mental Health Research Network; we ensured that participating Trusts represented a good cross-section of Trusts nationally (in terms of region, urban/rural setting and performance) before accepting all 14 for inclusion. The target number had been 12 initially, but over-sampling allowed for drop-outs. Using the UK Government Office Regions (1998), the selected Trusts represent the southern part of the North West England, the East of England, which is predominantly rural but includes major urban centres, the East and West Midlands, which includes three major cities, South West England, which includes major urban centres, and the South of England (south of London), which includes some mid-sized urban centres, and London. Thus, with the exceptions of the North East and Yorkshire and Humberside, all regions of England were represented. The selected Trusts from our sampled regions collectively represented urban and rural localities and those with high proportions of BME people (notably East and West Midlands).

In preparation for the submission of the documentation required by the NHS REC (see below), in principle agreement for these Trusts' participation in the project was obtained from their senior executives. They subsequently provided us with

contact names in their R&D departments to negotiate the access we would need once we had obtained a favourable opinion from the REC to proceed with the studies. However, before we had received the favourable opinion from the REC the senior executive of one of the Trusts withdrew her agreement for her Trust's participation in the project, leaving 13 participating in the project.

2.1.3 Participants

As noted above, participants were drawn from 13 Mental Health Trusts across England. They participated in ten workshops which focused on helping us develop an effectiveness measure of MPTW in CMHTs. Participants ($N = 157$) included service providers from all major professional groups (e. g., social work, psychiatry, psychology, occupational therapy and nursing, and including administrators and unqualified support workers) and from all types of CMHTs (e.g., Early Intervention, Crisis Resolution and Home Treatment), as well as service users and carers. The ten workshops were divided into three phases (see Table 2.1). Following ProMES methodology, Phase 1 focused on establishing what the outcomes of effective CMHTs are. Phase 2 considered how these outcomes could be measured using individual scale items, and finally Phase 3 involved the cognitive testing of these items by the participants to ensure that the questions were properly understood. In light of feedback some changes of wording were made. Details of each of these workshop phases are now presented.

Table 2.1
Numbers of Stage 1 workshop participants

Phase	Date (2010)	Location	Service providers	Service users	Carers	Total per workshop	Total per phase
1	12 May	Birmingham	20	7	5	32	
1	19 May	London	20	8	5	33	65
2	27 May	Birmingham	6	n/a	n/a	6	
2	01 Jun	London	6	n/a	n/a	6	
2	07 Jun	Nottingham	10	n/a	n/a	10	
2	15 Jun	Birmingham	n/a	8	n/a	8	
2	16 Jun	Birmingham	n/a	n/a	9	9	
2	25 Jun	Gloucester	6	n/a	n/a	6	45
3	07 Jul	Birmingham	10	7	6	23	
3	15 Jul	London	20	3	1	24	47
Grand total	-	-	98	33	26		157

2.1.4 Workshops

Phase 1 workshops

The first stage of ProMES requires the design team to reach a consensus over the objectives of the organisation. These are often general in nature, and typically include objectives such as optimizing customer satisfaction, ensuring health and safety or maximising revenues [56]. For our research, this step was achieved via two large workshops comprising Phase 1. These two externally-facilitated, whole day workshops involved service providers, users and carers representing 13 NHS Trusts in England. The overall aim of these workshops was for the project investigators and researchers present to listen to participants' accounts of working in (for staff) and experience of (for users and carers) CMHTs. Specifically, we aimed to find out from our participants: what an effective team is like; what an effective team does; and, what an effective team achieves. These three questions formed the basis for the structure of the workshop which was planned by the research team. An external facilitator highly experienced in the design and management of workshops and focus groups with health care professionals, took charge of the overall delivery, and was supported by four members of the research team. The workshop comprised of five sessions which are briefly summarised below;

- Session 1: 'What works for me?' This session required participants to work in pairs to reflect on what counts as success to them, in terms of working in or with community mental health teams. After sharing experiences with a partner, a whole group dialogue then followed, coordinated by the facilitator. Researchers captured the discussion on flip charts and in their own notes.
- Session 2: 'What we do to make a difference'. In this session, participants were organised according to their professional group, or whether they were a service user or carer, forming small groups of around five. Service provider groups discussed how they contribute to particular successes (identified from session 1), and what they need from their team and the wider organisation in order to achieve this success in future. Service user and carer groups were asked about what contributes to particular

successes in CMHTs from their perspective, and again what they think CMHTs need to achieve this success in future. Each group captured their thoughts on flip charts and shared key points in a whole group dialogue.

- Session 3: 'How do teams work to support good outcomes for patients?' Participants were placed into mixed groups to discuss particular examples and experiences about working with CMHTs. They were asked to describe experiences of 'good team effort' which contributed to positive outcomes for service users and carers. Specific questions they were asked to consider were 'what do people do to help the team work well?'; 'what is the most challenging aspect of working well in a team?'; and 'what do others outside the team do to help or hinder team efforts?' Again, sub-groups recorded their own discussion points on flip charts and fed back to the whole group at the end of the session.
- Session 4: 'What are the challenges to effective team working?' Participants were again mixed into new groups to discuss a current challenge or difficultly that they face with in their team. Service users and carers were asked to think of experiences they've had with their own CMHTs to discuss a team-related challenge or problem that they were aware of and how this could be resolved. Again, groups recorded their own discussion points on flip charts and fed back to the whole group.
- Session 5 'What have you got from today?' Participants were asked to partner with someone they had not yet worked with and discuss three questions; 'what did you already know but has been reinforced today?'; 'was there anything new?'; and 'are there still some things that are a bit of a mystery?'. Again, the session closed with a whole group dialogue in which researchers made notes on the discussion.

Throughout the sessions, the project investigators and researchers present joined the participants in their discussions, and probed relevant areas further, making their own notes throughout the process. The workshop closed with remarks from the research team about the importance of the research project, the valuable input the participants provided in the workshop, and relevant information regarding feedback and participation in Phase 2.

In order to analyse the data and extract the major themes or 'objectives' from the Phase 1 workshops, we followed the steps of thematic analysis outlined by Braun and Clarke [57](2006). These steps firstly involve becoming familiar with the data through immersion. Two members of the research team therefore immersed themselves in the qualitative data using both the researcher notes and flip charts and discussed the content between them at length. The next step involved generating initial codes by highlighting the text, before searching for overall themes in the data. At this stage, seven major themes became apparent and were named as follows; service user recovery; provision of continuous care; therapeutic relationships with service users; effective inter-team working; responsiveness to carers; creative problem solving; and, respect between the different representatives of the different disciplines in CMHTs. We then reviewed these themes with other members of the research team who had also attended the workshops and revisited the data to check there was nothing we had missed. A summary of these outcomes is given in Table 2.2, which shows that seven major team effectiveness themes were derived. Following the principles of grounded theory data analysis, these themes were induced from the data

through immersion in them and subsequent discussion between two of the authors of this report. These represent the seven major objectives of CMHTs, as required by the first stage of the ProMES methodology. These themes are shown in Table 2.2.

Table 2.2
Phase 1 workshop outcomes on effective MPTW by theme

Theme	Exemplar flip chart statements
Focus on service user recovery	Putting the patient at the centre of the team Meeting the needs of patients Working with people during and beyond recovery to improve longer term outcomes and opportunities Recovery is a shared responsibility between patients and professionals The team makes a positive impact on someone's quality of life
Therapeutic relationships between staff & service users	Providing a safe environment When I am feeling unsafe in my life in the outside world, it helps enormously to have somewhere safe to go where I can relax and express myself safely Compassion Felt the pain with me. Sit alongside me and share my journey. Listen and hear the pain, accept me, take me seriously and care about what happens
Continuity of care	Having the same people visit you Consistent medical advice – no conflicting messages
Effective inter-team working	Cooperative interdependence between teams Effective inter-team working – over transition periods
Engagement with carers	Transparency and openness (confidentiality) Carer involvement in decision making
Creative solutions to service user problems (innovative healthcare delivery)	Positive risk taking and minimising risk through creative solutions Taking positive risks – setting challenging but realistic goals Being prepared to challenge and take risk
Respect between different disciplines represented in teams	Teams going the extra mile, not just working to the job description By working closely together through a shared value/philosophy you are able to achieve an outcome that has been agreed as a goal Shared culture/philosophy, trust Shared responsibility Respect and understanding for different professions

Phase 2 Workshops

The second stage of ProMES requires the design team to develop 'indicators' which form quantifiable measures of how well each objective is being met. The main purpose of the process of structured discussion in the Phase 2 workshops was therefore to elicit the participants' ideas about each of the Phase 1 themes, and how participants would know whether these themes are happening or not.

Phase 2 consisted of six half day workshops facilitated by two of the project researchers. As the workshops were much smaller in size (between 6 and 10 participants), the research team felt able to facilitate the workshops effectively themselves, without the involvement of the external facilitator. Four workshops were for service providers, one was for service users and the other one was for carers. We chose to have separate workshops for users and carers in this phase because, during Phase 1, we became aware that these two groups of stakeholders have different and often conflicting views about MPTW in mental health care. This had the effect at times of hampering the open exchange of views.

Indeed, in describing the ProMES methodology, Pritchard (1990) points out that 'constructive disagreement' between members of the design team is good, and that making these different perspectives visible is vital. Holding stakeholder-specific Phase 2 workshops therefore ensured that different perspectives were teased out and properly explored, before bringing stakeholders back together for Phase 3 in order to reach an overall consensus. Further, in order to ensure that the outcomes of the Phase 1 workshops were indeed reliable and representative of all stakeholder perspectives, we conducted three subsequent validity checks. Firstly, following the Phase 1 workshop, each participant received a summary report outlining the key findings of the workshop, structured around the seven derived themes. A covering letter provided an opportunity for further comment on anything they felt was missing, or not sufficiently captured in the summary report. The research team received a number of positive responses from all stakeholder groups, although no suggestions for amendments to the themes were made. Secondly, the research team presented the results of the Phase 1 workshops at a service user and carer event held shorter afterwards at Birmingham University. The research received a significant amount of interest and both service users and carers at the event were satisfied with the seven themes presented. Finally, at the beginning of each Phase 2 workshop, participants were given a brief insight into the methodology and results of Phase 1, after which they had the opportunity to comment on the validity and completeness of the themes. Again, as no major concerns were raised, the research team felt confident the results from Phase 1 were an accurate representation of all stakeholder perspectives.

Each Phase 2 workshop aimed to focus on three or four of the seven derived themes from Phase 1 (depending on time available). The focus themes of each workshop were rotated to ensure that all seven themes were explored in

sufficient depth. As discussed earlier, each workshop began with a de-briefing exercise, summarising and discussing the outcomes of Phase 1. The remaining time was structured around two sessions;

- Session 1: One of the seven themes was introduced as a topic area, and participants were provided with a sheet of quotes of the Phase 1 workshop relating to this theme. With these quotes in mind, as well as their own thoughts on the topic, participants were asked to discuss two questions with fellow group members; 'If (topic name) was happening, how would we know?'; and 'If (topic name) was not happening, what would we see?' Participants were encouraged to provide specific examples of what each topic looks like in practice. Researchers probed for these examples to be in behaviour terms where possible.
- Session 2: Dependent on the size of the workshop, participants were separated into smaller groups (between two to five members) to repeat the session 1 exercise using a different theme. After completing the exercise, sub-groups then shared their discussion points in a whole group dialogue. Again, all data was recorded on flip charts and in the researchers' notes.

Again, we used thematic analysis techniques to analyse the data, the outcomes of which are shown in Table 2.3. The same two researchers involved in the Phase 1 analysis built on the articulation of the themes and their associated statements in Table 2.3 to generate between 10 and 15 items for each theme for possible inclusion in the effectiveness questionnaire. This ensured that, in addition to the generic team questions which constitute the ATPI survey instrument, there was a specific scale focused on multi-professional team working in mental health teams. Examples of such items for the theme of "Respect between professionals" are "Decisions that are made within my team are usually dominated by the input of one professional group" and "Patients receive a direct benefit because of the inter-disciplinary composition of our team". The project investigators were subsequently invited to review and comment on the total pool of 80 items, specifically in relation to face and content validity (face validity being the extent to which a test appears to measure what it is intended to measure, and content validity the extent to which a measure tests what it sets out to test). As a result, the wording of some items was changed.

Table 2.3
Phase 2 Workshops: Summary of key outcomes

If 'service user recovery' was happening, what would we see?
Observable signs of change in the patient: correct medication which successfully manages symptoms
Holistic approach: Improved self-esteem and quality of life of the patients (social functioning, satisfying relationships and opportunities for a future)
Patients feeling empowered and supported in making choices for themselves to achieve their full potential
Improvement in patient's self-awareness and independence = less patient contact
An observant team which listens to the patient, never gives up hope and help him/her to rebuild routines, plan, and to be forward looking
A dynamic relationship between professionals = optimum level of team functioning and consistency
Regular meetings involving patients to discuss future support
Increased efficiency – short waiting times/good communication/moving through the system quickly
Achievement of team and patient outcomes and targets
Withdrawal of treatment
If 'responsiveness to carers' was happening, what would we see?
Happy/satisfied carers
Patient updates: frequent feedback and open communication
Reciprocating carers. If providers know where carers are, carers know where providers are
Education about carers' role
Healthy caring – allowing patient freedom to make choices
Carers being treated as part of the team
If 'inter-team working' with service users is developed, what would we see?
Good, clear communication
Clarity of roles – everyone involved in a case is aware of who is accountable/taking ownership
Fluid patient journey
Efficiency - no repetition of administration tasks (i.e., taking patient details numerous times)
Demonstrating good practice leading to reduced risks
Greater flexibility in roles where people are willing and motivated to go the extra mile
Improved morale and well-being of team workers
Reduced risk for clients i.e., system is set up to manage risk (such as knowing history of care, etc.)
Flexible patient assessments – not assuming that one size fits all.
Clear referral processes
Accessible service – so not 9 to 5, but 24/7
Collaborative – working with not against other teams and services
If 'creative problem solving' was happening, what would we see?
Equal partners at the table
Service and care plan needs to be tailored to patient needs. If the service doesn't meet patient needs then it is not a service
Better application of treatment plans and team organisation
Practicality – damage limitation
Empowered, engaged and involved patients
Recognition/acceptance that not everything is going to work, but there is a willingness to try
Having a vision - goal setting, routine, future planning

Learning to see the way through a problem and think outside of the box

Seeing patient as a whole person (body and mind) - balanced lifestyle, social friendships, interests

Regular contact between team members and patient/carer

Efficient facilitation and encouragement of recovery

Reduced stigma, discrimination, less labelling of patients

Reduced/flatter hierarchy - creative solutions, less task orientated. Idea generation and sharing

If 'respect between professionals' is happening, what would we see?

Mutual respect within hierarchies - healthy interdisciplinary conflict within an open culture

Holistic interventions and person-centred care plans allowing patients to feel valued

Culture of understanding and willingness to learn from/understand each other.

Good leadership: clear boundaries - people know and understand what's going on

'Seamless' services: collaborative, transparent, honest joint-working between teams and services

Working effectively with risk – not just 'passing it on'

Communication - a common understanding/language within the team

If 'provision of continuous care' is happening, what would we see?

Seamless and creative transition through service

Effective communication which is clear and not confusing

Gradual and agreed preparation of the patient for discharge

Awareness of and adaptability to patient needs to promote independence and recovery of patient

An effective skills mix within an adequately resourced team

Positive experiences for patients and carers who will feel valued

Strategy: continuity in care planning, treatment, goal setting and goal achieving at each stage

Needs to be a genuine and positive recovery/well-being approach

If 'therapeutic relationships' with service users is happening, what would we see?

Time dedicated to listening to patients - 'advanced directives' – can include confidentiality

Treating people holistically, rather than on basis of diagnosis alone

Relationships between service providers and patients that are based on support, trust, empathy and truth

Retention and continuity of staff is important

Regular home visits - setting for interventions would be in less stigmatising locations (away from clinics for example)

Well-defined boundaries (direct relationship with patient – trust and confidence instilled which increases speed of recovery)

Clear expectations - fewer complaints

Positive, challenging and objective view

Explanation of relationship to clarify how long a patient is likely to remain within one team and what will happen next

Underlying drivers/objectives which the patient can work on

Patient has a stake in his/her own care

Phase 3 workshops

Based on the items generated from the Phase 2 analysis, Phase 3 was concerned with the refinement and validation of the list of items which would form the final CMHT effectiveness scale. This stage is not explicitly outlined in a typical ProMES methodology, but is an important step in the development of a new scale [58, 59]. The Phase 3 workshops were whole day, externally-facilitated events involving service providers, users and carers. As these were large workshops (involving 23 and 24 participants respectively), we again appointed the same external facilitator from Phase 1 to lead the workshops to ensure they ran effectively. Several researchers and co-investigators were also present at each.

The major purpose of these workshops was to enable further cognitive testing of the face and content validity by these major stakeholder groups with a view to identifying the most suitable 20 or so items from our pool of around 80 for possible inclusion in the ATPI used in Stage 2 (see below). The participants worked in small groups, spending one hour working on each of the themes from Table 2.3. Each group was asked to discuss, evaluate and, if necessary, discard, refine or reword the proposed questionnaire items. During the day each group worked on all of the items for each theme. Members of the research team joined these groups to help facilitate discussion. At the end of the day, the workshop participants were asked independently to weight the importance to them of each of the themes. Each participant received a strip of ten stickers. Using these stickers as a form currency, we asked participants to distribute them in whichever way they liked across the seven themes, which written on large flip charts and spread around the room. This exercise forced participants to decide which theme(s) they considered most important in capturing the effectiveness of CMHTs. We subsequently used the frequency counts of stickers to determine the proportion of items needed to tap each of the themes in order to reflect the aggregated weightings.

Following detailed analysis of the outcomes of these workshops and discussion between researchers, the Phase 3 list of over 80 potential questionnaire items was reduced to the target of 20 for possible inclusion in the ATPI questionnaire. This final list was subsequently discussed at a User and Carer Project Advisory Group meeting. This discussion resulted largely in confirmation that the items were appropriate and relevant for inclusion in the questionnaire for Stage 2 of the project. Only minor amendments were suggested and accepted.

2.2 Results

The final CMHT scale is shown in Table 2.4. This scale consists of 20 items twelve of which are positively worded and the remaining eight negatively worded. The mix of negatively and positively worded items was intended to reduce the possibility of acquiescent bias (yes-set), which is the tendency for respondents to "go on auto-pilot" and agree to all of the scale items [60]. Our purpose was to encourage respondents to consider each item in the scale carefully and provide meaningful responses to them. The themes are not equally weighted in that there are not an equal number of items for each theme, as noted earlier. This reflects the relative importance attached to each theme by

the Phase 3 workshop participants. Items were randomly presented in the questionnaire rather than being grouped by theme.

Table 2.4
Final CMHT effectiveness scale by Phase 1 theme

Improved service user well-being 1. Helping service users improve their sense of well-being is a major goal of my team (item 81) 2. My team helps service users to build positive aspects of their lives (item 85) 3. *My team does not involve service users in developing their own care plans* (item 88) 4. My team encourages service users to take the next step on the path to their recovery (item 83) 5. Taking service users' views into account is important in my team (item 96)
Creative problem solving 1. My team acknowledges that one size does not fit all service users (item 90) 2. My team explores new ways of providing service user care (item 89) 3. *Sharing knowledge and experience of good practice is not a feature of my team's work* (item 86)
Continuous Care 1. *Service users rarely receive care from the same members of my team* (item 94) 2. When necessary, my team contacts other teams and agencies to share information about service users (item 80) 3. To help ensure continuity of care my team is flexible in managing its workload (item 95)
Inter-team working 1. *My team's referral processes are unclear to many of us* (item 84) 2. *My team does not communicate effectively with other mental health teams in the Trust* (item 92)
Respect between professionals 1. *There is a lack of mutual respect between the members of my team* (item 97) 2. Regardless of professional background, my team members are willing to learn from one another (item 87)
Responsiveness to carers 1. *Carers are not seen as very important by my team* (item 99) 2. My team offers information about services to carers (item 91)
Therapeutic relationships with service users 1. *Professional boundaries between service users and staff in my team are poorly defined* (item 82) 2. In my team, relationships with service users are based on openness (item 93) 3. In my team, we listen to service users and work collaboratively with them (item 98)

Note. Negatively worded items in italics (see above for explanation). Item numbers have been randomly assigned and represent where in the ATPI each item appears but without its theme name.

The psychometric properties of the scale were tested in Stage 2 of the research, based on responses from 1500 service providers in 135 CMHTs. These are reported in Chapter 3.

2.3 Conclusions

Stage 1 resulted in the new contextually specific measure (see Table 2.4) of effective MPTW in mental healthcare, based on input from all major stakeholder groups. As will be reported in chapter 3, above the psychometric properties of the scale are good, suggesting that this is an instrument that will bear repeated use in this setting.

The strong guidance provided by the major stakeholders – service providers, users and carers – in the development of the instrument was an important contributor to its psychometric robustness and its fitness-for-purpose. Moreover, the workshops demonstrated that it is possible to use the ProMES-based methodology for the purpose of developing measures of effectiveness for health and social care teams. **We therefore strongly recommend the application of our ProMES based methods to developing similar team effectiveness instruments for use with practitioners in other health and social care contexts.**

For this programme of research, the seven domains of effectiveness identified provide a useful framework for the third (qualitative) stage of the research. Moreover, these domains provide service providers, users and carers with an important and relatively lean conceptual map for understanding what effectiveness constitutes in the context of mental health care team performance. This map can be used by service providers to self assess; by service users and carers to review the services they receive from teams; by audit bodies such as the Care Quality Commission to inform the criteria they use; by commissioners of services to assess the performance of the teams they commission; and by policy makers and the general public both to understand what it is they should be looking for in assessing the delivery of mental health care by teams of professionals. **The identification of these domains therefore offers important guidance to a range of interested stakeholders. The domains are:**

- **improved service user well-being,**
- **creative problem solving,**
- **continuous care,**
- **inter-team working,**
- **respect between professionals,**
- **responsiveness to carers, and**
- **therapeutic relationships with service users**

Moreover, the information presented in the tables above provides stakeholders with a more articulated and detailed understanding of what these domains consist of. We will ensure that the domain specification and underlying details are made available to both those who have participated in the research and a wider stakeholder audience.

3 Chapter 3: Stage 2 (Team Survey)

Chapter Summary

Introduction
This chapter describes the second major stage of the study, a survey of 135 community-based adult mental health teams across 11 Trusts. Due to its lengthy nature, the chapter is summarised over the following four pages.

Methods
Teams were recruited via the Clinical Studies Officers (CSOs) appointed by the MHRN to work in each Trust. All teams within each Trust were based in a single locality (usually coterminous with a primary care Trust and/or local authority), and were invited to participate by the CSO directly.

The sample included 120 teams which participated in the online survey, and 15 completing it via a traditional postal survey. 2233 questionnaires were sent out, and responses from exactly 1500 team members were received, resulting in an overall response rate of 67.2%.

Several types of specialist or generic team were included in the survey, the three most common being Generic CMHTs (32 teams), Rehabilitation & Recovery (26 teams) and Early Intervention (22 teams).

The questionnaire comprised three types of questions: background information about the respondents and their teams, the 100-item Aston Team Performance Inventory and the new 20-item CMHT effectiveness scale, developed in Stage 1. A variety of psychometric methods, including exploratory and confirmatory factor analysis and reliability analysis, were used to test the new effectiveness scale, with the conclusion being that a single overall score for effectiveness in each team was the best way of representing the data rather than in its seven separate components.

Analysis and Results
The analysis showed clearly that Early Intervention teams performed the best in all areas, followed by assertive outreach teams and older adults CMHTs. Generic CMHTs were typically the worst performing.

The results for team inputs suggested that Early Intervention teams had the best task design and team effort and skills. Generic CMHTs had the poorest scores in general. Results from Substance Misuse teams were sometimes lower, but as there were only three of these in the sample this difference was often not significant. Older adults CMHTs fared much better, having the best scores for organisational support and resources.

The results for team processes suggested that Early Intervention teams and Crisis Resolution/Home Treatment teams had the best processes. Those of generic CMHTs were consistently poorer than those in Early Intervention teams, and often worse than those in Assertive Outreach and CRHT teams.

Rehabilitation and Recovery and Substance Misuse teams fared badly in terms of team objectives.

The results for leadership processes indicated that leadership of Early Intervention teams was the best across the board, and that in generic CMHTs it was significantly worse. There were no other (statistically) significant differences.

In terms of ATPI outputs, Early Intervention teams again came out best in most categories, the exception being that older adults CMHTs had the best score for inter-team relationships. For team innovation, Early Intervention teams were significantly better than not only generic CMHTs, but also Assertive Outreach, Rehabilitation and Recovery, and Substance Misuse teams. Older Adults CMHTs were also more innovative than generic CMHTs.

For the CMHT effectiveness scale, Early Intervention teams came out much better than all other team types. Older adult CMHTs also fared well, particularly for responsiveness to carers.

Although at first sight it would appear that team size was related to many of the ATPI and effectiveness variables, these correlations were almost entirely explained by the differences by team type. Controlling for type of team, there were no significant relationships between team size and ATPI or effectiveness variables.

Predictors of Team Effectiveness
We examined to what extent the inputs, team processes and leadership processes sections of the ATPI predict overall CMHT effectiveness. We did this via a series of regression models, controlling for both team type and Trust. The results suggested that, overall, mental health teams were most likely to be effective when they were able to be creative, when there was good communication and joint decision-making, and when they were led effectively. Having good organisational support and the right team effort and skills would appear to be ways to foster these conditions.

Differential effects by types of team
In terms of team inputs, the variable that most consistently predicted effectiveness was team effort & skills. For generic CMHTs, however, the organisational support available was most important, and in older adults CMHTs the resources available to the team appeared particularly crucial. Task design was also important for all the specialist team types.

For team processes, the strongest predictor of effectiveness throughout was creativity. Task focus and participation (communication and decision making) were also widely important. For generic CMHTs, reflexivity was particularly important, and team conflict appeared to be particularly harmful for effectiveness.

For team leadership, the common thread was the importance of good management. However, for assertive outreach teams, "Leadership 3" appeared to be more important, and for rehab & recovery teams strong leadership was

more important. Throughout, however, all three seemed to be important predictors of effectiveness.

Overall, creativity and task focus were the two factors that had the most consistent association with effectiveness. However, for generic CMHTs these were outweighed by organisational support, and for older adults CMHTs, resources available to the team were also highly important.

Predictors of other outcomes
The ATPI included five outcomes of its own: team member satisfaction, attachment, team effectiveness, inter-team relationships, and innovation. Regression and relative weight analysis were used to examine the association between inputs, team processes and leadership processes, and each of these outcomes in turn.

There were clear differences in the importance of inputs and processes predicting each outcome. For team member satisfaction, the most important factors were participation in decision making, and (absence of) team conflict. Coaching by the team leader, and creativity, were also relatively important. Organisational support and resources appeared to be less important for satisfaction.

Similarly, for attachment (the extent to which members felt attached to, and wished to remain part of, the team), participation and (lack of) team conflict were the most important predictors, with coaching and creativity also important. Team innovation was a slightly different outcome, measuring the extent to which the team develops new services and ways of working. Unsurprisingly, by far the most important predictor of this was the process of creativity, which covers the support available for creativity and innovation. However, reflexivity (the extent to which team members take time out to reflect on their effectiveness and act upon the results), and task design (which includes the level of autonomy in a team) were also important predictors.

Testing the model
The ATPI model was based on the inputs-processes-outputs model of team working, in which the inputs given to a team (task design, team effort and skills, organisational support, resources) contributed to the team processes (objectives, reflexivity, participation, task focus, lack of team conflict, creativity) and leadership processes to create positive outcomes for the team. This implies that the effects of the team inputs on outcomes occurred via team and leadership processes, although there may have been some direct effects also. In order to test this, we used a path analysis approach, in which each team input predicted each process as well as each outcome, each process predicted each outcome, and we used bootstrapping to test whether each possible indirect (mediated) relationship was significant.

For the main CMHT effectiveness outcome, there were indirect effects from both task design and team effort and skills. In both cases, the only significant specific mediator was creativity, suggesting that (one of) the main reason(s) that these inputs are important for effectiveness was that they provided teams with the necessary skills and structure to be creative and innovative.

For team member satisfaction, the same two inputs were also those to have the larger effects, and again they provide the two significant indirect effects also. In particular, task design had a moderate indirect effect on satisfaction via participation, and team effort and skills had a large indirect effect via both participation and creativity.

Overall, there was a clear picture that the two consistently most important team inputs – task design and team effort and skills – improved the conditions for team effectiveness and well-being because they allowed teams to achieve greater participation and support for creativity.

Team composition and diversity
We also studied the effect of team composition in terms of both demographic and work-related variables.

Few significant diversity effects existed, and most of those that were found involved age. Higher age diversity was associated with greater respect between professionals, higher team member satisfaction and attachment, as well as better inter-team relationships. This suggested that having a more age diverse team may be associated with better interpersonal relationships both within and outside the team.

Conclusions
From both the team type analysis and the model testing, it was clear that teams with a clearer, more focussed task design and composition (including team effort and skills) were those that were the most effective, and this appeared to be (at least in part) because they enabled greater levels of participation in decision making, and more creative approaches to working.

3.1 Introduction

Stage 2 of the study involved a questionnaire survey to team members in 11 of the Trusts recruited at Stage 1. The 11 Trusts were representative of all mental health trusts nationally in terms of extent of team working according to the 2009 NHS national staff survey (the closest in time to when Trusts were electing to participate), with 41% of staff in Trusts participating in the study working in well-structured teams, and the same percentage of staff in Trusts not participating in the study.

The aim of this stage was to identify the contextual factors, other inputs and those team processes that most powerfully influence the effectiveness of adult community-based mental health teams. This included studying the effects of team inputs, team processes, team leadership, and team composition (including diversity) on a range of outcome variables, including the CMHT effectiveness scale developed during Stage 1 of this study.

The questionnaire was based around the Aston Team Performance Inventory [50], which is a comprehensive and well-validated measure of team inputs, processes and outputs. A substantial national and international database of responses from healthcare teams has been compiled using the ATPI.[3]

3.2 Methods

3.2.1 Sample

Teams were recruited via the Clinical Studies Officers (CSOs) appointed by the MHRN to work in each Trust. All teams within each Trust were based in a single locality (usually coterminous with a primary care Trust and/or local authority), and were invited to participate by the CSO directly. The main benefit of participation was a free benchmarked feedback report detailing how teams compared with the wider sample on each dimension of the ATPI and CMHT effectiveness scale. The reports also suggested areas of strength and possible areas for improvement. CSOs then forwarded details of team members to the research team, who would then send out an invitation by email to complete an online questionnaire (in most cases), or by post to complete a traditional paper questionnaire (in a few cases where IT provision was not considered appropriate).

In total, 1500 responses were received from 135 teams. This included 120 teams which participated in the online survey, and 15 completing it via a traditional postal survey. 2233 questionnaires were sent out, resulting in an overall response rate of 67.2%. The response rate for those teams using postal methods was significantly lower (34.0%) than those doing it online (71.8%) (chi-square =154.6, 1 d.f., p < 0.001).

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[3] The inputs-processes-outputs model of team working is a widely used and well-understood model, and although it has been criticised on conceptual grounds by some authors [57], they recognise that the I-P-O framework has had a "powerful influence on recent empirical research" (p. 519)

Of the 1500 respondents, 72.3% were female. 7.0% were under 30, 20.9% between 30 and 39, 37.6% between 40 and 49, 29.7% between 50 and 59, and 4.8% 60 or older. 82.3% described themselves as White British. These characteristics were close to the national profile of community-based staff in mental health trusts according to the 2009 NHS national staff survey, where 73.8% were female, 80.4% White British and the age profile also very similar.

The most common occupational group was community psychiatric nurses (CPNs), who accounted for 32.6% of the sample. Admin/clerical staff (11.4%) and social workers (11.1%) came next, followed by psychiatrists (7.9%), occupational therapists (6.5%), support time recovery workers (STRs, 5.5%), clinical psychologists and other nurses (each 5.1%), with 1.2% describing themselves as other medical practitioners, and 13.6% as other occupational groups (which were largely joint roles or slight variations on the above descriptions). These percentages were broadly similar to those for community-based mental health staff in the 2009 NHS national staff survey, with some slight discrepancies because of the specific make-up of these teams (e.g. social workers are less represented in the NHS national staff survey as they are not necessarily employed by the trust directly).

The majority (73.9%) of the respondents worked in only one team, but 17.0% worked in two, 4.8% in three, 2.6% in four, 0.6% in five and 1.0% in more than five. Psychiatrists and clinical psychologists were the most likely to work across more than one team. The mean time spent in post was 7.0 years, with the mean team tenure 5.0 years.

The numbers of teams of each type and respondents therein are shown in Table 3.1. "Generic CMHTs" refers to those Community Mental Health Teams without a specific service user profile or task, also sometimes referred to as primary care liaison teams or other similar names.

Table 3.1
Responses by type of team

Type of team	Number of teams	Number of respondents	Response rate (%)
Generic CMHT	32	366	63.2
Assertive Outreach	18	163	69.7
Early intervention	22	204	64.4
Crisis Resolution/Home Treatment	11	138	64.5
Rehabilitation & recovery	26	335	74.8
Older adults CMHT	20	230	66.3
Substance Misuse	3	30	55.6
Intensive support	1	15	86.7
Liaison psychiatry	1	7	85.7
Assertive outreach/R&R	1	18	83.3

The teams were drawn from 11 different localities, each situated in a different Trust (two Trusts from the first stage declined to participate in the survey). The responses by Trust (anonymised) were as follows:

Table 3.2
Responses by Trust

Trust	Number of teams	Number of respondents	Response rate (range) (%)
Trust A	19	236	73.8 (33.3-90.0)
Trust B	6	42	71.2 (45.5-100.0)
Trust C	12	114	50.4 (15.0-92.6)
Trust D	11	115	54.8 (25.9-81.8)
Trust E	13	120	57.4 (23.3-88.9)
Trust F	9	111	75.5 (38.9-100.0)
Trust G	14	152	61.3 (16.7-86.7)
Trust H	15	196	68.3 (27.3-90.9)
Trust I	7	71	88.8 (78.6-100.0)
Trust J	11	113	72.4 (54.5-87.5)

3.2.2 Study variables

The questionnaire comprised three types of questions:
- Background information about the respondents and their teams
- The 100-item Aston Team Performance Inventory [53]
- The new 20-item CMHT effectiveness scale, developed in Stage 1

We have summarised the background information above. For the ATPI, we first describe the dimensions and examine the reliability of each scale assessing that dimension. For the new CMHT effectiveness measure, we perform exploratory and confirmatory factor analysis as well as reliability analysis.

3.2.2.1 Aston Team Performance Inventory

The Aston Team Performance Inventory [53] comprises 100 items across 18 dimensions of team inputs, team processes, leadership processes[4] and team outputs. Full text of the items can be found in appendix 1, but a list of the dimensions in each category, together with a description of the components of each, can be found in Table 3.3.

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[4] Most of the 18 dimensions of the ATPI are clearly delineated. The one area where there is more overlap is in the leadership processes section; the ATPI has historically used the terms "leading", "managing" and "coaching" to denote these, but the authors of this report acknowledge these do not necessarily align with all definitions of these terms in the leadership literature. To avoid confusion, we label these as "leadership 1", "leadership 2" and "leadership 3" in this report, noting that the effects of leadership on team performance in our sample are very similar. Where distinctions can be drawn, we identify the key differences between the dimensions in the text.

Scale reliability (internal consistency), as calculated by Cronbach's alpha, of each of the ATPI scales is shown in Table 3.4. It can be seen that all scales have a reliability of at least 0.80, and therefore can be considered reliable [62]. Inter-rater reliability is considered later.

Table 3.3
Summary of ATPI scales

	No. items	Components/description
Team inputs		
Task design	11	Autonomy, task relevance, complete task, feedback, task interdependence
Team effort and skills	8	Team member motivation, Appropriateness of skills, team potency
Organisational support	11	Information and communication, training for team working, climate for team working
Resources	4	Resources provided to the team
Team processes		
Objectives	3	Clarity of, commitment to, and agreement about team objectives
Reflexivity	4	Reflection on performance
Participation	7	Decision making processes, Communication, regular meetings, and trust, safety and support
Task focus	6	Concern with quality, service user focus, constructive debate and error management
Team conflict	5	Task and interpersonal conflict
Creativity	3	Practical support, and climate, for creativity and innovation
Leadership processes		
Leadership 1	4	Extent to which team leader sets direction, acquires resources, and supports innovation
Leadership 2	8	Extent to which team leader guides teams towards effective processes, monitors performance, gives helpful feedback, encourages inter-team working, and recognises and rewards performance
Leadership 3	5	Availability, concern for individual team members, encouragement and support, and encourages learning from error
Team outputs		
Team member satisfaction	6	Satisfaction with recognition for contribution, responsibility, team member support, influence over decisions, team openness and how conflicts are resolved
Attachment	3	Feeling of attachment to team and its members
Team effectiveness	3	Managerial praise, goal achievement
Inter-team relationships	5	Co-operation, and absence of destructive conflict, with other teams
Team innovation	4	Development of new products, services, and ways of working

Table 3.4
Reliability of ATPI scales

ATPI scale	Cronbach's alpha
Task design	0.80
Team effort and skills	0.87
Organisational support	0.86
Resources	0.84
Objectives	0.85
Reflexivity	0.82
Participation	0.90
Task focus	0.80
Team conflict	0.80
Creativity	0.82
Leadership 1	0.85
Leadership 2	0.94
Leadership 3	0.92
Team member satisfaction	0.90
Attachment	0.86
Team effectiveness	0.80
Inter-team relationships	0.82
Team innovation	0.89

3.2.2.2 CMHT Effectiveness Scale

Following established practice for scale development [63], we first split the sample at random into two halves. The first half was used for exploratory factor analysis; the second for confirmatory factor analysis and reliability testing.

Exploratory factor analysis

Exploratory factor analysis (EFA) on the 20 items was performed using principal axis factoring and a direct oblimin (oblique) rotation – considered the most appropriate methods for organisational data where factors are likely to be correlated [64]. The first factor accounted for 39.4% of the total variance; the second a further 6.1%, the third 5.3%, with subsequent factors all explaining 4.6% or less (which would also have eigenvalues less than 1). This suggests that a single factor may adequately cover the effectiveness domain, although a second factor may prove useful too and possibly even a third.

Further clarity is given by studying the rotated factor solutions (pattern matrices). These are shown in the table below: full text of the items can be found in Table 3.5. Factor loadings of magnitude at least 0.4 are shown in bold as they represent the items that most contribute towards those factors.

Table 3.5
Exploratory factor analysis of CMHT effectiveness scale

	One factor	Two factors		Three factors		
cmht1	**0.58**	**0.46**	-0.15	**0.45**	-0.18	-0.20
cmht2	**0.68**	**0.70**	0.01	**0.69**	-0.02	-0.18
cmht3	**-0.41**	0.02	**0.50**	0.03	**0.52**	0.10
cmht4	**0.66**	**0.72**	0.05	**0.69**	0.02	0.00
cmht5	**-0.41**	0.05	**0.54**	0.03	**0.52**	-0.02
cmht6	**0.73**	**0.83**	0.11	**0.81**	0.07	-0.05
cmht7	**-0.50**	0.01	**0.61**	0.00	**0.59**	-0.13
cmht8	**0.66**	**0.43**	-0.27	**0.42**	-0.26	0.27
cmht9	**-0.55**	-0.26	0.34	-0.26	0.36	0.09
cmht10	**0.64**	**0.55**	-0.11	**0.57**	-0.07	0.35
cmht11	**0.72**	**0.70**	-0.04	**0.68**	-0.05	0.03
cmht12	**0.65**	**0.65**	-0.01	**0.64**	-0.04	-0.13
cmht13	**-0.60**	-0.16	**0.52**	-0.16	**0.52**	0.04
cmht14	**0.59**	**0.62**	0.03	**0.61**	0.01	0.06
cmht15	-0.33	-0.09	0.28	-0.08	0.31	0.13
cmht16	**0.62**	**0.49**	-0.16	**0.49**	-0.14	0.23
cmht17	**0.77**	**0.76**	-0.02	**0.75**	-0.03	0.08
cmht18	**-0.46**	-0.04	**0.49**	-0.03	**0.49**	-0.20
cmht19	**0.78**	**0.83**	0.03	**0.81**	0.01	0.06
cmht20	**-0.51**	-0.31	0.24	-0.30	0.27	0.14

A number of things are quickly apparent from this analysis. First, the three factor solution adds nothing useful to the two factor solution, as the third factor has no high factor loadings, and the first two factors are almost identical to the two factor solution. This two factor solution, however, appears to take the negatively worded items into a separate factor (a method-related factor), rather than anything to do with the content. Therefore this is probably not an advantage over the one factor solution. All items load onto the single factor solution, with the exception of item 15 ("Service users rarely receive care from the same members of my team"). Therefore, four different solutions were tested by confirmatory factor analysis:

- A single factor solution containing all items
- A single factor solution containing all items except item 15
- A two-factor solution based on the EFA results
- A seven-factor solution based on the original seven domains from the workshops in Stage 1

Confirmatory factor analysis

Fit indices for the four competing models are shown in the Table 3.6. As a guide, the standardised root mean residual (SRMR) should ideally be below 0.1, the comparative fit index (CFI) above 0.90, the Tucker-Lewis index (TLI) above 0.90, and the root mean square error of approximation (RMSEA) below 0.08 [65].

Table 3.6
Confirmatory factor analysis of CMHT effectiveness scale

Model	Chi-square (df)	SRMR	CFI	TLI	RMSEA
1 factor (20 items)	687.4 (170)	0.044	0.904	0.893	0.068
1 factor (19 items)	634.6 (152)	0.043	0.909	0.897	0.069
2 factors	456.6 (118)	0.037	0.930	0.919	0.066
7 factors	548.5 (149)	0.040	0.926	0.906	0.064

Interestingly, there is little to choose between the models on the basis of fit. The two-factor model appears marginally better than the others, but this would not be so theoretically meaningful, as the factors could only really be distinguished as "effectiveness" and "ineffectiveness", rather than being based on separate domains of effectiveness. The 7-factor solution appears to fit reasonably, but there are inadmissibly large correlations between the factors and a complete lack of discriminant validity (as well as parsimony) in the model.

Therefore we are left to choose between the two single factor solutions: although dropping item 15 improves some fit indices, it worsens others, and so it was decided to maintain all 20 items in the measure as a single effectiveness construct. The seven domains uncovered in Stage 1 are better thought of as components of the reliability dimension, rather than separate dimensions in their own right.

The reliability of the overall scale was demonstrated by a Cronbach's alpha of 0.91 (which was the same even if item 15 were excluded).

Due to the task-specific nature of some of the scale items, the analysis was repeated for each of the four team types with sufficient responses (at least 200 individuals) to enable such analysis. In each case a single factor solution appeared to be better than a multiple-factor solution, with a two-factor model representing a split between positive and negative items. This single factor had a reliability of between 0.89 and 0.92 in each case.

Therefore, a single effectiveness factor was carried forward as the main dependent variable for the analysis, although the seven domains were retained for some specific analyses.

3.2.3 Data aggregation

As the majority of analysis is focused on the team level (team effectiveness and innovation being the outcome variables of interest), it was necessary to aggregate all of these scales to the team level. Therefore in this section we provide details on inter-rater reliability and agreement.

Inter-rater reliability is measured using ICC (2) [66]. It is usually thought to be sufficient if values are above 0.70, although values of 0.50 are considered marginally acceptable [67].

Inter-rater agreement is measured using $r_{WG(J)}$ [68. Although the commonly used cut-off of 0.70 for acceptable levels of agreement has been disputed [62], it still gives a benchmark as to how much agreement there is amongst team members.

Both these statistics can be found for the ATPI scales and for the overall CMHT effectiveness scale in Table 3.7. It can be seen that all scales meet the minimum requirement for inter-rater reliability, indicating that aggregation can continue, although in many cases the reliability is below the ideal 0.70 level. Conversely, the inter-rater agreement statistics are very large, with all scales averaging over 0.80 across the teams (and many above 0.90). This tends to suggest that there is a good level of agreement between team members on all dimensions, further supporting the aggregation to the team level.

Table 3.7
Inter-rater reliability and agreement

Scale	ICC(2)	Mean $r_{WG(J)}$
Task design	0.68	0.96
Team effort and skills	0.70	0.94
Organisational support	0.71	0.95
Resources	0.70	0.87
Objectives	0.66	0.89
Reflexivity	0.60	0.88
Participation	0.73	0.93
Task focus	0.59	0.93
Team conflict	0.77	0.92
Creativity	0.65	0.87
Leadership 1	0.77	0.90
Leadership 2	0.77	0.95
Leadership 3	0.75	0.90
Team member satisfaction	0.54	0.92
Attachment	0.53	0.83
Team effectiveness (ATPI)	0.73	0.81
Inter-team relationships	0.62	0.92
Team innovation	0.64	0.90
CMHT effectiveness	0.57	0.99

This then supports the planned analysis at the team level, with team effectiveness and other outcomes (including team member satisfaction and attachment, which are referent-shift constructs according to Chan's [69] typology) as team level dependent variables. Individual level outcomes are not appropriate, thus analysis at the individual level (including multilevel analysis) is not necessary or desirable except in certain specific circumstances.

3.3 Analysis and Results

3.3.1 Descriptive statistics and correlations

Means and standard deviations (at the team level) and inter-correlations between the 18 ATPI scales and the CMHT effectiveness scale are shown in Table 3.8. It can be seen that there are some fairly sizeable correlations both between ATPI scales, and between ATPI scale and CMHT effectiveness. This prompts possible concerns about multi-collinearity of predictors in subsequent analyses that will have to be dealt with.

Table 3.8
Means, standard deviations and inter-correlations of main questionnaire scales

	Mean	SD	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.
1. Task design	3.61	0.27																		
2. Team effort and skills	3.68	0.36	0.80																	
3. Organisational support	3.28	0.32	0.65	0.66																
4. Resources	2.66	0.46	0.50	0.51	0.45															
5. Objectives	3.78	0.38	0.83	0.86	0.65	0.35														
6. Reflexivity	3.44	0.35	0.77	0.70	0.60	0.28	0.76													
7. Participation	3.82	0.40	0.80	0.87	0.58	0.41	0.83	0.75												
8. Task focus	3.83	0.29	0.79	0.79	0.53	0.39	0.81	0.77	0.85											
9. Team conflict	2.36	0.41	-0.53	-0.63	-0.51	-0.23	-0.56	-0.43	-0.72	-0.51										
10. Creativity	3.65	0.39	0.72	0.79	0.54	0.42	0.82	0.68	0.87	0.76	-0.61									
11. Leadership 1	3.67	0.45	0.71	0.76	0.64	0.47	0.72	0.58	0.69	0.64	-0.58	0.64								
12. Leadership 2	3.79	0.45	0.73	0.74	0.62	0.41	0.70	0.61	0.72	0.65	-0.61	0.64	0.96							
13. Leadership 3	3.87	0.46	0.65	0.71	0.54	0.35	0.67	0.57	0.67	0.62	-0.55	0.58	0.93	0.94						
14. Team member satisfaction	3.75	0.34	0.69	0.75	0.59	0.37	0.71	0.63	0.85	0.71	-0.72	0.76	0.76	0.79	0.76					
15. Attachment	4.01	0.37	0.51	0.65	0.43	0.27	0.58	0.49	0.73	0.58	-0.63	0.63	0.62	0.65	0.65	0.83				
16. Team effectiveness	2.95	0.49	0.70	0.63	0.66	0.36	0.64	0.56	0.59	0.51	-0.54	0.58	0.73	0.74	0.67	0.69	0.53			
17. Inter-team relationships	3.03	0.35	0.48	0.53	0.59	0.33	0.51	0.33	0.49	0.44	-0.56	0.50	0.62	0.60	0.51	0.58	0.46	0.57		
18. Team innovation	3.50	0.39	0.73	0.67	0.59	0.43	0.69	0.68	0.69	0.66	-0.50	0.79	0.65	0.64	0.55	0.68	0.54	0.71	0.51	
19. CMHT effectiveness	4.19	0.22	0.69	0.74	0.57	0.34	0.74	0.65	0.80	0.72	-0.60	0.80	0.68	0.69	0.64	0.79	0.68	0.60	0.54	0.77

3.3.2 Differences by team type

To indicate the differences between types of team across the whole ATPI, the following chart shows the average scores across the different ATPI dimensions for each of team inputs, team processes, leadership processes and outputs. Note that relatively little interpretation can be made of these findings because it is difficult to assign a meaning to such overall variables; nevertheless, it shows clearly that Early Intervention teams perform the best in all areas, followed by assertive outreach teams and older adults CMHTs. Generic CMHTs are typically the worst performing (substance misuse teams are often at least as poor, if not worse, but there are only three of these in the sample so conclusions about them are limited).

Figure 3.1
Overall ATPI scores by team type
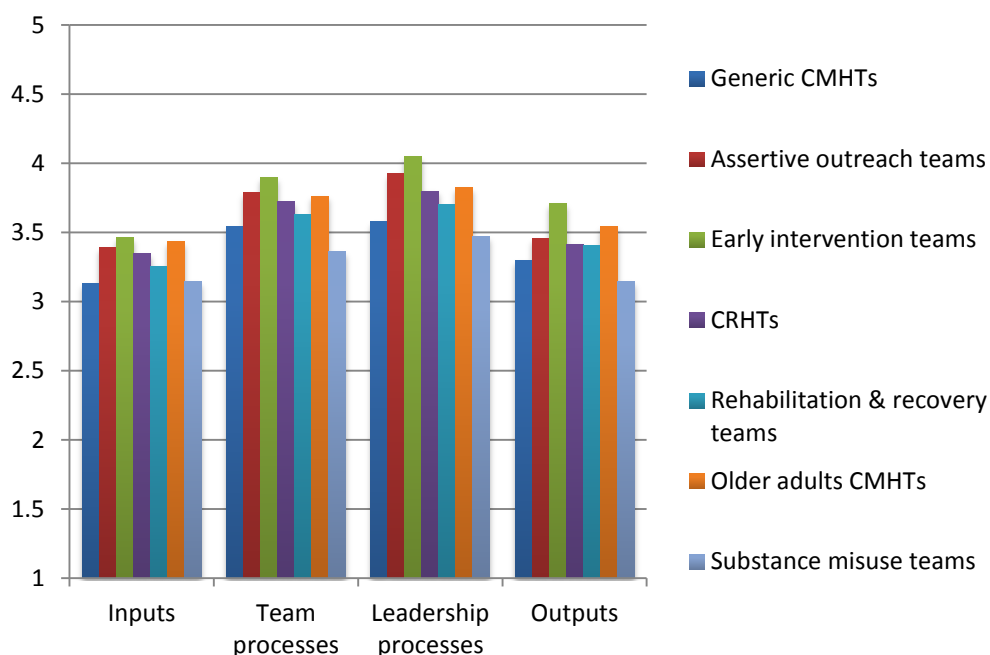
The overall mean scores for each team type[5] are shown in tables 3.9-3.13, separately for inputs, team processes, leadership processes, ATPI outcomes and CMHT effectiveness. For each dimension, the best mean score is shown in bold. Those that are significantly lower than other team type mean scores are indicated by table footnotes. Note that, as there are only three substance misuse teams, results for these should not be treated as so reliable as other team types. In all cases, the dimensions were based on Likert scales ranging from 1-5, with 1 representing the lowest possible score on the construct in question, and 5 the highest possible score. With the exception of "team conflict", higher scores were more desirable on all dimensions.

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[5] Excluding those team types with only one in the sample

Table 3.9
Team inputs by type of team

Type of team	Task design	Team effort & skills	Organisational support	Resources
Generic CMHT	3.42[abcd]	3.53[b]	3.15[d]	2.41
Assertive Outreach	3.73	3.78	3.27	2.77
Early intervention	**3.80**	**3.87**	3.38	2.79
CRHT	3.71	3.70	3.23	2.75
Rehab & recovery	3.56[b]	3.54[b]	3.27	2.66
Older adults CMHT	3.66	3.80	**3.47**	**2.81**
Substance misuse	3.28[ab]	3.45	3.15	2.70

[a] Significantly lower than Assertive Outreach teams
[b] Significantly lower than Early Intervention teams
[c] Significantly lower than CRHT teams
[d] Significantly lower than Older Adults CMHTs

The results for team inputs suggest that Early Intervention teams have the best task design and team effort and skills, indicating that the model followed by these teams is more effective than those of other teams (particularly generic CMHTs, Rehabilitation & Recovery and Substance Misuse teams). Generic CMHTs have the poorest scores in general. Results from Substance Misuse teams were sometimes lower, but as there were only three of these in the sample this difference is often not significant. Older adults CMHTs fare much better, having the best scores for organisational support and resources, although the latter score is not significantly higher than those for other team types.

Table 3.10
Team processes by type of team

Type of team	Objectives	Reflexivity	Participation	Task focus	Team conflict	Creativity/ innovation
Generic CMHT	3.58[abd]	3.26[abc]	3.65[b]	3.69[bc]	2.39	3.46[b]
Assertive Outreach	3.91	3.58	3.97	3.93	2.38	3.69
Early intervention	**4.03**	3.56	**4.05**	3.96	**2.18**	**3.94**
CRHT	3.87	**3.63**	3.81	**4.00**	2.52	3.54
Rehab & recovery	3.66[b]	3.42	3.75	3.79	2.46	3.63
Older adults CMHT	3.89	3.48	3.85	3.85	2.21	3.71
Substance misuse	3.34[b]	3.01	3.45	3.50	2.49	3.37

[a] Significantly lower than Assertive Outreach teams
[b] Significantly lower than Early Intervention teams
[c] Significantly lower than CRHT teams
[d] Significantly lower than Older Adults CMHTs

The results for team processes suggest that Early Intervention teams and crisis resolution/home treatment teams have the best processes. Those of generic CMHTs are consistently poorer than those in Early Intervention teams, and often worse than those in Assertive Outreach and CRHT teams also. Rehabilitation and Recovery and Substance Misuse teams fare badly in terms of team objectives.

Table 3.11
Leadership processes by type of team

Type of team	Leadership 1	Leadership 2	Leadership 3
Generic CMHT	3.46[b]	3.57[b]	3.71[b]
Assertive Outreach	3.79	3.93	4.05
Early intervention	**3.96**	**4.06**	**4.13**
CRHT	3.66	3.81	3.92
Rehab & recovery	3.61	3.72	3.78
Older adults CMHT	3.76	3.86	3.86
Substance misuse	3.42	3.48	3.52

[b] Significantly lower than Early Intervention teams

The results for leadership processes indicate that leadership of Early Intervention teams is the best across the board, and that in generic CMHTs it is significantly worse. There are no other (statistically) significant differences. It is worth bearing in mind that the correlations between leadership process scales are very high, and therefore it is not surprising that identical results are found for each of the three.

Table 3.12
ATPI outputs by type of team

Type of team	Team member satisfaction	Attachment	Team effectiveness	Inter-team relationships	Team innovation
Generic CMHT	3.65[b]	3.95	2.73	2.90[d]	3.26[bd]
Assertive Outreach	3.80	4.06	2.98	3.00	3.44[b]
Early intervention	**3.96**	**4.24**	**3.30**	3.19	**3.86**
CRHT	3.75	4.00	2.86	2.99	3.48
Rehab & recovery	3.71	3.87	2.92	2.99	3.54[b]
Older adults CMHT	3.78	4.03	3.08	**3.24**	3.57
Substance misuse	3.35	3.95	2.55	2.81	3.07[b]

[b] Significantly lower than Early Intervention teams
[d] Significantly lower than older adults CMHTs

In terms of ATPI outputs, there are no significant differences for attachment, or the (generic) team effectiveness scale. Early intervention teams again come out best in most categories, the exception being that older adults CMHTs have the best score for inter-team relationships. For team innovation, Early Intervention teams are significantly better than not only generic CMHTs, but also Assertive Outreach, Rehabilitation and Recovery, and Substance Misuse teams. Older Adults CMHTs are also more innovative than generic CMHTs.

Table 3.13
CMHT effectiveness by type of team

Type of team	Overall	Improved service user well-being	Creative problem solving	Continuous care
Generic CMHT	4.12[b]	4.27[b]	3.91[b]	4.06[b]
Assertive Outreach	4.16[b]	4.26[b]	4.05[b]	4.14[b]
Early intervention	**4.43**	**4.62**	**4.34**	**4.38**
CRHT	4.14[b]	4.28[b]	4.09	3.92[bd]
Rehab & recovery	4.13[b]	4.30[b]	4.03[b]	4.11[b]
Older adults CMHT	4.22[b]	4.28[b]	4.05[b]	4.21
Substance misuse	3.95[b]	4.09[b]	3.86	3.85[b]
	Inter-team working	Respect between professionals	Responsiveness to carers	Therapeutic relationships
Generic CMHT	4.03	4.08	4.29[bd]	4.12[b]
Assertive Outreach	4.07	4.10	4.27[bd]	4.11[b]
Early intervention	**4.30**	**4.26**	**4.60**	**4.35**
CRHT	4.04	4.02	4.36	4.16
Rehab & recovery	3.85[bd]	3.99	4.30[bd]	4.10[b]
Older adults CMHT	4.19	4.13	4.55	4.15[b]
Substance misuse	3.88	3.95	3.93[bd]	3.94[b]

[b] Significantly lower than Early Intervention teams
[d] Significantly lower than Older Adults CMHTs

For the CMHT effectiveness scale, Early Intervention teams come out much better than all other team types. The only dimension where there are no significant differences between team types is respect between professionals. Older adult CMHTs also fare well, particularly for responsiveness to carers, where they are better than most other team types.

3.3.3 Differences by other background variables

Although at first sight it would appear that team size is related to many of the ATPI and effectiveness variables, these correlations are almost entirely explained by the differences by team type. The range of team sizes[6] for different team types is shown in Table 3.14.

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[6] In a few cases it was not known whether the total number of questionnaires sent out was equal to the exact team size; the sample size was used as a proxy in these cases.

Table 3.14
Team size by type of team

Type of team	Mean team size	Minimum	Maximum
Generic CMHT	18.72	4	35
Assertive Outreach	13.39	6	21
Early intervention	14.64	3	27
Crisis Resolution/Home treatment	19.73	11	38
Rehab & recovery	17.46	6	31
Older adults CMHT	17.35	5	47
Substance misuse	18.00	14	22
Intensive support	15.00	15	15
Liaison psychiatry	8.00	8	8
Assertive outreach/R&R	18.00	18	18

It can be seen that Assertive Outreach and Early Intervention teams (often the best scoring) are usually smaller than several other types, particularly the generic CMHTs and substance misuse teams, which tend to score worse than other types of team. Therefore it is not surprising that, controlling for type of team, there were no significant relationships between team size and ATPI or effectiveness variables (the differences between team types still being statistically significant). In other words, even though there are clear differences between team types which may be due to the task or team model, within team types there is no evidence that larger or smaller teams fare better or worse. This also holds when examining possible curvilinear effects of team size – there is no evidence of a significant relationship.

Because there were some very large teams in the sample (one with 47 members, and another four with between 31 and 38 members), we repeated this analysis without these large teams included, to check that outliers were not having an inordinate effect on the results. Again we found no significant relationships between team size and any of the scales. We repeated this analysis by team type, and still found that there were no significant relationships between size and any of the scales, despite the fact that a few would be expected by chance alone. Therefore we did not use team size as a control variable for most of our analysis: the exception being when we examined composition of the team or diversity as the independent variable.

However, there were still many significant differences by Trust, suggesting that this, as well as team type, should be controlled for in any overall analysis.

Within the research literature, there is evidence that team size is an important determinant of team effectiveness. Notably, researchers argue that teams should be as small as possible to ensure the task is performed effectively and, ideally, no larger than 8-10 members [70, 71]. Consideration should be given to the potentially problematic effects of working in teams of the size of some of those in the field. With a mean team size of around 18 and teams as large as 47,

effective team work becomes extremely difficult. Problems of communication, clarity about roles and effective meetings and decision making are likely to abound. Typically the solution is to identify sub tasks and build teams around these sub tasks. Groups of 18 to 47 are more properly described as small organizations rather than teams. Given the evidence on the potential dangers of working in entities in the health service called teams but that are not real teams, consideration should be given to their functioning and leadership [72].

3.3.4 Predictors of team effectiveness

For the first stage of this analysis, we examine to what extent the inputs, team processes and leadership processes sections of the ATPI predict overall CMHT effectiveness. We did this via a series of regression models, controlling for both team type and Trust.

It has already been seen that there are large correlations between different dimensions of the ATPI. This presents difficulties in analysing the data, as traditional models would give estimates that may be biased by multi-collinearity of predictors [73]. The inclusion of multiple predictors would likely lead to regression coefficients that were not individually interpretable, whereas models involving only individual predictors would fail to take into account shared variance with other dimensions.

Therefore we use the comparatively recent technique of relative importance analysis [74] to examine the importance of each predictor. In doing this we report not traditional regression coefficients, but raw relative weights – the proportions of variance in the dependent variable that can uniquely be attributed to each independent variable (calculated by regressing the dependent variable on each distinct subset of independent variables). The significance levels shown in tables 3.15-3.18 relate to those found under backwards elimination, i.e. the maximum number of variables that have significant effects which are independent of each other. However, these are less relevant for this analysis as variables are not expected to have fully independent effects and these are shown for the sake of completeness only. Parameters for control variables are not shown for the purpose of expediency (a total of 16 dummy variables are used for these in each case). As suggested by Table 3.8, all effects are in the expected direction: i.e. positive except for team conflict, which had negative relationships with effectiveness.

Table 3.15
Inputs as predictors of CMHT effectiveness

ATPI variable	Raw relative weight
Task design	0.152
Team effort and skills	0.216***
Organisational support	0.108*
Resources	0.032

* $p < .05$; ** $p < .01$; *** $p < .001$

The results show that team effort and skills (comprising team member motivation, appropriateness of skills and team potency) are the most important predictors of the inputs. Task design has the second highest level of importance, but is not independently significant (perhaps being too closely linked to team effort and skills). Organisational support, however, is significant, with only resources having a small effect.

Table 3.16
Team processes as predictors of CMHT effectiveness

ATPI variable	Raw relative weight
Objectives	0.095
Reflexivity	0.084
Participation	0.121**
Task focus	0.104
Team conflict	0.080
Creativity	0.141**

* $p < .05$; ** $p < .01$; *** $p < .001$

The two team processes that come out as the most important predictors of effectiveness are participation and creativity. Participation refers to the extent of both communication and joint decision making, whereas creativity is about the practical support and climate for creativity and innovation.

Table 3.17
Leadership processes as predictors of CMHT effectiveness

ATPI variable	Raw relative weight
Leadership 1	0.139
Leadership 2	0.149***
Leadership 3	0.124

* p < .05; ** p < .01; *** p < .001

Although all three variables have strong relative weights, it is the second leadership dimension (which relates to monitoring performance, giving feedback, encouraging inter-team working, rewarding good performance, and guiding the team towards effective processes) that emerges as the single most important predictor of effectiveness. It is worth re-emphasising the high inter-correlations between the three variables, however, as this explains why only one retains statistical significance, and also why the relative weights are very similar.

Table 3.18
All inputs and processes as predictors of CMHT effectiveness

ATPI variable	Raw relative weight
Task design	0.043
Team effort and skills	0.054
Organisational support	0.038
Resources	0.013
Objectives	0.052
Reflexivity	0.048
Participation	0.075**
Task focus	0.064
Team conflict	0.046
Creativity	0.098***
Leadership 1	0.045
Leadership 2	0.049**
Leadership 3	0.045

* p < .05; ** p < .01; *** p < .001

The results suggest that, overall, mental health teams are most likely to be effective when they are able to be creative, when there is good communication and joint decision making, and when they are led effectively. Having good organisational support and the right team effort and skills would appear to be ways to foster these conditions.

3.3.5 Differential effects by types of team

For the five types of team with at least 18 representatives in the sample, this analysis was repeated. Full results are shown in Table 3.19. Significance tests involving backwards elimination were not performed for each team type, owing to the small numbers in each subset (meaning such tests are either impossible or results are unstable). A summary of results for each team type, and an overall summary, follow. The figures shown are the raw relative weights, allowing a comparison across types of team so that it can be seen how the contribution of a particular input (for example) compares between two team types.

Table 3.19
Predictors of CMHT effectiveness for each team type

	Generic CMHTs	Assertive Outreach Teams	Early Intervention Teams	Rehab & Recovery Teams	Older Adults CMHTs
Task design	0.037	0.067	0.064	0.076	0.041
Team effort and skills	0.041	0.073	0.083	0.067	0.091
Organisational support	0.113	0.032	0.021	0.033	0.052
Resources	0.007	0.012	0.036	0.045	0.103
Objectives	0.043	0.096	0.042	0.081	0.086
Reflexivity	0.097	0.089	0.025	0.086	0.066
Participation	0.061	0.119	0.090	0.068	0.091
Task focus	0.029	0.138	0.121	0.116	0.067
Team conflict	0.074	0.068	0.035	0.050	0.032
Creativity	0.091	0.117	0.176	0.095	0.120
Leadership 1	0.057	0.054	0.038	0.068	0.065
Leadership 2	0.074	0.057	0.048	0.057	0.074
Leadership 3	0.064	0.065	0.033	0.066	0.058

Note. Figures in table are raw relative weights for regression sets including all predictors

Generic CMHTs:
- The most important input was organisational support
- Reflexivity and absence of team conflict were the most important team processes
- "Leadership 2" was still the most important leadership process
- Overall, organisational support is a more important predictor of effectiveness than any of the processes

Assertive Outreach teams:
- Team effort & skills and task design are the most important inputs
- Task focus and creativity are the most important team processes
- The most important leadership process is "Leadership 3", which relates to encouragement and support for individual team members
- Overall, team processes are the important predictors of effectiveness: task focus, creativity and participation in particular

Early Intervention teams:
- Team effort & skills and task design are again the most important inputs
- Creativity, participation and task focus are all important team processes
- "Leadership 2" was the most important leadership process
- Overall, team processes are the important predictors of effectiveness: as with Early Intervention teams, task focus, creativity and participation are particularly strong

Rehabilitation and Recovery teams:
- Yet again, team effort & skills and task design are again the most important inputs
- All team processes (other than team conflict) have relatively equal importance, but with objectives coming out the strongest of all
- "Leadership 1" (relating to setting team direction, acquiring the necessary resources and supporting innovation) is the most important leadership process
- Overall, though, task focus and creativity are the most important predictors of effectiveness in rehab & recovery teams

Older Adults CMHTs:
- Team effort & skills and resources are the most important inputs
- Creativity and participation are the most important team processes
- "Leadership 2" is the most important leadership process, closely followed by "leadership 1"
- Overall, creativity is the most important predictor of effectiveness, closely followed by resources

Summary of effects for different team types

In terms of **team inputs**, the variable that most consistently predicts effectiveness is team effort & skills (including sub-dimensions of team member motivation, appropriateness of skills and team potency – the latter referring to the team's collective belief in its ability to perform effectively and succeed). For generic CMHTs, however, the organisational support available (in terms of

provision of information/communication, and training and climate for team working) is most important, and in older adults CMHTs the resources available to the team appear particularly crucial. Task design (autonomy, having a complete task to perform, task relevance, feedback and interdependence) was also important for all the specialist team types.

For **team processes**, all six were variously important at different times. However, the strongest predictor of effectiveness throughout was creativity (encompassing both climate, and practical support, for creativity and innovation). This suggests that when teams are set up with the ability to be creative in their approach (within the limits of what is required), they are more likely to be effective. Task focus and participation (communication and decision making) were also widely important. For generic CMHTs, reflexivity was particularly important, and team conflict appeared to be particularly harmful for effectiveness. For rehabilitation & recovery teams, having clear, shared objectives was the most important process.

For **team leadership**, the common thread was the importance of good management . However, for assertive outreach teams, "Leadership 3" appeared to be more important, and for rehab & recovery teams strong leadership was more important. Throughout, however, all three seemed to be important predictors of effectiveness, and this reflects the correlations indicating that when leaders are strong on one, they are generally strong on the other two as well.

Overall, creativity and task focus are the two factors that have the most consistent association with effectiveness. However, for generic CMHTs these are outweighed by organisational support, and for older adults CMHTs, resources available to the team are also highly important.

3.3.6 Predictors of other outcomes

The ATPI includes five outcomes of its own: team member satisfaction, attachment, team effectiveness, inter-team relationships, and innovation. Regression and relative weight analysis were used to examine the association between inputs, team processes and leadership processes, and each of these outcomes in turn.

Table 3.20 shows the results of this analysis. There are clear differences in the importance of inputs and processes predicting each outcome. For team member satisfaction, the most important factors were participation in decision making, and (absence of) team conflict. Coaching by the team leader, and creativity, were also relatively important. Organisational support and resources appear to be less important for satisfaction, although there was some evidence that the effect of organisational support differed by type of team ($p = .028$), with the effect being substantially less important in older adults CMHTs than in other types of team.

Similarly, for attachment (the extent to which members feel attached to, and wish to remain part of, the team), participation and (lack of) team conflict are

the most important predictors, with coaching and creativity also important. It is worth noting that, for both satisfaction and attachment, team objectives has a smaller, but independent, effect – this suggests that having clear, shared objectives may not contribute as much to individual well-being as participation (for example), but it is a distinct effect that would occur whether or not the other factors were present. There were no differential effects by type of team for attachment.

Table 3.20
Predictors of ATPI outcomes

	Team member satisfaction	Attachment	Team effectiveness	Inter-team relationships	Innovation
Task design	0.043	0.026	0.078**	0.023	0.066*
Team effort and skills	0.058	0.051	0.040	0.030	0.046
Organisational support	0.039	0.018	0.093**	0.083**	0.043
Resources	0.017	0.010	0.022	0.020	0.030
Objectives	0.045**	0.033**	0.039	0.028	0.051
Reflexivity	0.042	0.028	0.039	0.016	0.070*
Participation	0.099**	0.089**	0.032	0.027	0.050*
Task focus	0.057	0.042	0.025	0.025	0.048
Team conflict	0.095	0.077	0.035	0.067**	0.027
Creativity	0.078*	0.057	0.034	0.033	0.117**
Leadership 1	0.064	0.046	0.064	0.065**	0.042
Leadership 2	0.077	0.054	0.077**	0.059	0.045**
Leadership 3	0.079**	0.069**	0.058	0.040*	0.030*

Note. Figures in table are raw relative weights for regression sets including all predictors

The ATPI team effectiveness scale is generic and perhaps less relevant for this study, due to the presence of the more specific CMHT effectiveness scale that we have already examined. However, it relates more to the extent to which the team is told it is doing well (by the team leader or others); as a result, it is perhaps not surprising that the amongst most important predictors here are organisational support and managing, with task design as the other predictor of a similar magnitude. No differential effects were found by type of team.

The inter-team relationships outcome assesses the extent to which teams work co-operatively, without destructive conflict, with other teams within and outside their organisation. This is also one of the domains of CMHT team effectiveness as uncovered in Stage 1 of our study. The most important predictor of inter-team relationships was organisational support, suggesting that having the right organisational structures in place is imperative. Absence of intra-team conflict is also very helpful, with "Leadership 2" (monitoring performance, giving feedback, encouraging inter-team working, rewarding good performance, and guiding the team towards effective processes) the next most important predictor, suggesting that strong leadership is key in enabling good inter-team processes. No differential effects were found by team type.

Team innovation is a slightly different outcome, measuring the extent to which the team develops new services and ways of working. Unsurprisingly, by far the most important predictor of this is the process of creativity, which covers the support available for creativity and innovation. However, reflexivity (the extent to which team members take time out to reflect on their effectiveness and act upon the results), and task design (which includes the level of autonomy in a team) are also important predictors.

There was also some evidence that the effects of objectives ($p = 0.013$) and participation ($p = 0.009$) differed by team type. Specifically, in rehab & recovery teams objectives had a greater positive effect on innovation than in generic CMHTs, whereas in generic CMHTs, objectives were the more important predictor.

3.3.7 Testing the overall model (mediation)

The ATPI model (Figure 3) is based on the inputs-processes-outputs model of team working, in which the inputs given to a team (task design, team effort and skills, organisational support, resources) contribute to the team processes (objectives, reflexivity, participation, task focus, lack of team conflict, creativity) and leadership processes to create positive outcomes for the team. This implies that the effects of the team inputs on outcomes occur via team and leadership processes, although there may be some direct effects also.

Figure 3.2
The ATPI model
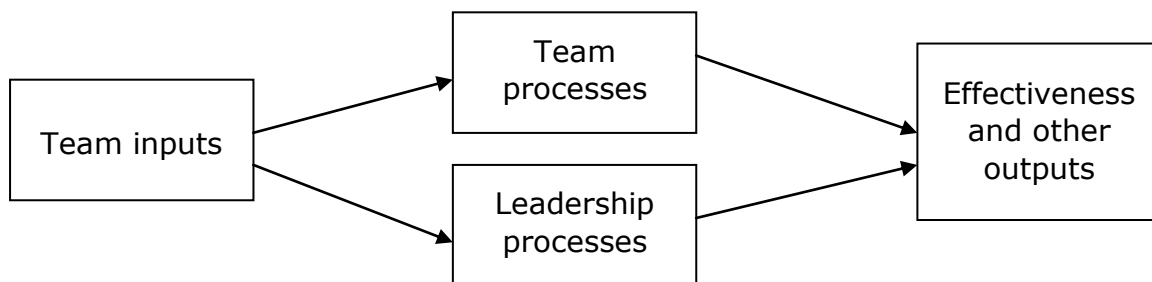
In order to test this, we used a path analysis approach, in which each team input predicted each process as well as each outcome, each process predicts each outcome, and we used bootstrapping[7] [75] in Mplus 6 [76] to test whether each possible indirect (mediated) relationship was significant. Full results of this analysis, in the form of Mplus output, are available on request; however, Table 3.21 summarises the results by showing how for each pair of inputs and outcomes, what the total indirect effects were, and also which specific mediators were significant.

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[7] Bootstrapping is a non-parametric statistical technique involving repeated resampling of data to get parameter estimates; it is now generally considered the best method of analysis for estimating mediated effects

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Table 3.21
Mediators of inputs-outputs relationships

Input	Output	Total indirect effect	Significant mediators
Task design	CMHT effectiveness	0.191*	Creativity (0.089*)
Team effort & skills	CMHT effectiveness	0.317***	Creativity (0.173***)
Organisational support	CMHT effectiveness	0.004	-
Resources	CMHT effectiveness	-0.003	-
Task design	Satisfaction	0.275*	Participation (0.206**)
Team effort & skills	Satisfaction	0.582***	Participation (0.330**), Creativity (0.115*)
Organisational support	Satisfaction	0.024	-
Resources	Satisfaction	-0.030	-
Task design	Attachment	0.276	-
Team effort & skills	Attachment	0.599***	Participation (0.393**)
Organisational support	Attachment	0.024	-
Resources	Attachment	-0.046	-
Task design	Team effectiveness	0.011	-
Team effort & skills	Team effectiveness	0.156	-
Organisational support	Team effectiveness	0.174	-
Resources	Team effectiveness	0.020	-
Task design	Inter-team relationships	0.029	-
Team effort & skills	Inter-team relationships	0.283	-
Organisational support	Inter-team relationships	0.125	-
Resources	Inter-team relationships	0.039	-
Task design	Innovation	0.248	-
Team effort & skills	Innovation	0.277*	Participation (-0.260*), Creativity (0.494***)
Organisational support	Innovation	0.078	-
Resources	Innovation	0.033	-

Note. Figures shown are standardised indirect path coefficients

The path analysis model was an unrestricted one, meaning that there were no degrees of freedom and therefore no estimates of model fit, as all variables in the model were allowed to be related to all other variables. This is important because, although mediated relationships are predicted by the input-process-output model on which the ATPI is based, it is still reasonable to assume that, for example, team effort and skills, or resources, could have a direct effect on team effectiveness, as well as via team processes. The direct effects of both inputs and processes have been examined in previous sections, hence the focus on mediators in this section.

The presence of indirect (mediated) effects appears to be dependent on the specific outcome variable, as well as the specific independent variable. For the main CMHT effectiveness outcome, there were indirect effects from both task design and team effort and skills – the two inputs that had the most important effects on the outcome. In both cases, the only significant specific mediator was creativity, suggesting that (one of) the main reason(s) that these inputs are important for effectiveness is because they provide teams with the necessary skills and structure to be creative and innovative.

For team member satisfaction, the same two inputs were also those to have the larger effects, and again they provide the two significant indirect effects also. In particular, task design has a moderate indirect effect on satisfaction via participation, and team effort and skills has a large indirect effect via both participation and creativity. This suggests that teams with the right task design and personnel are likely to involve more people in decision making and communication, which leads to greater satisfaction.

For attachment, only team effort and skills had a significant indirect effect, albeit a large one. This time participation was the only significant mediator, suggesting that the reason team composition is important for team member attachment is because of the benefits of everyone participating in decision making, communication etc.

There were no indirect effects for either the ATPI team effectiveness variable or for inter-team relationships. For the team innovation outcome, however, team effort and skills again had a significant indirect effect, via both participation and creativity, suggesting that again it is the involvement of all team members, together with an environment supportive of creativity, which enables the effort and skills of team members to be translated into innovative outcomes.

It is worth noting that these results do not suggest that other processes are not important, nor that there are no other variations of the inputs-processes-outputs paths that would explain the performance of different teams. These are highlighted as the most important, though, because they are statistically significant in a model of many highly inter-correlated variables. Overall, there is a clear picture that the two consistently most important team inputs – task design and team effort and skills – improve the conditions for team effectiveness

and well-being because they allow teams to achieve greater participation and support for creativity.

3.3.8 Team composition and diversity

We also studied the effect of team composition in terms of both demographic and work-related variables. Due to the specific nature of some aspects of the CMHT effectiveness scale and its components, we examined the components separately as well as together for this analysis.

For each of the 13 outcome variables (the CMHT effectiveness scale and its seven components individually, and the five ATPI outcomes) we ran regression models that studied (jointly) % male staff in the team, average age level, % white staff, average team tenure, % nursing staff, % medical staff, % admin staff and % social workers within each team. Additionally, we then studied the effects of diversity on these five characteristics (sex, age, ethnicity, occupational group and tenure), in separate models that controlled for all of the earlier compositional characteristics. All models also controlled for team type, Trust, and team size.

It is noteworthy that these regression models included many (up to 29) independent variables, meaning there was relatively low power for the tests of interest. However, this means that those significant effects found can be more trusted, especially when similar patterns are found across different variables, despite the large number of tests performed.

Diversity was measured as follows:
- Sex diversity – Blau's index [77]
- Age diversity – Blair and Lacy's "*l*" statistic for ordinal variables [78]
- Ethnic diversity – Blau's index (based on the 16 categories as used in the UK census)
- Job diversity – Number of different jobs represented [48]
- Tenure diversity – Range [11]

These measures fit with Harrison and Klein's [79] typology of diversity insofar as they distinguish between separation (for demographic characteristics) and variety (for job-related characteristics).

We now summarise the results for each dependent variable in turn:

Overall CMHT effectiveness
Compositional effects – there were no significant main effects of sex, age, tenure, ethnicity or occupational group makeup.

Diversity effects – there was no evidence of any effects of team diversity on the overall CMHT effectiveness outcome.

CMHT effectiveness: Improved service user well-being
Compositional effects – higher scores were achieved in teams with a higher proportion of nurses (unstandardised $\beta = 0.417$, $p = .001$) and psychiatrists ($\beta = 0.619$, $p = .008$). These effects are such that a 10% increase in the proportion of psychiatrists within the team, for example, would be associated with an improvement of 0.062 in the effectiveness score, and so are relatively modest in size.

Diversity effects – there was no evidence of any effects of team diversity on the outcome.

CMHT effectiveness: Creative problem solving
Compositional effects – higher scores were found in teams with a higher proportion of nurses ($\beta = 0.412$, $p = .009$) and a higher proportion of clerical/administrative staff ($\beta = 0.597$, $p = .029$).

Diversity effects – none of the diversity indices quite reached statistical significance. However, both age diversity ($\beta = 0.447$, $p = .052$) and tenure diversity ($\beta = 0.008$, $p = .057$) almost did so, thus providing some suggestion that a greater range of experience within the team could lead to more creative problem solving.

CMHT effectiveness: Continuous care
Compositional effects – higher scores were achieved in teams with more social workers ($\beta = 0.598$, $p = .004$).

Diversity effects – there was no evidence of any effects of team diversity on the outcome.

CMHT effectiveness: Inter-team working
Compositional effects – there were no significant main effects of sex, age, tenure, ethnicity or occupational group makeup.

Diversity effects – there was no evidence of any effects of team diversity on the outcome.

CMHT effectiveness: Respect between professionals
Compositional effects – there were no significant main effects of sex, age, tenure, ethnicity or occupational group makeup.

Diversity effects – teams with higher age diversity ($\beta = 1.140$, $p = .001$) tended to have higher scores on this dimension.

CMHT effectiveness: Responsiveness to carers
Compositional effects – higher scores were found in teams with a higher mean team tenure ($\beta = 0.024$, $p = .046$), suggesting that effective relationships with carers develop better over time. There was also a positive association with the proportion of female team members ($\beta = 0.319$, $p = .036$).

Diversity effects – there was no evidence of any effects of team diversity on the outcome.

CMHT effectiveness: Therapeutic relationships with service users
Compositional effects – teams with a higher proportion of psychiatrists (and/or other medical staff) had higher scores on this outcome ($\beta = 0.456$, *p* = .048).

Diversity effects – there was no evidence of any effects of team diversity on the outcome.

Team member satisfaction
Compositional effects – higher scores were found in teams with a higher proportion of nursing staff ($\beta = 0.487$, *p* = .023).

Diversity effects – age diversity ($\beta = 0.748$, *p* = .016) was positively related to team member satisfaction, as was occupational group diversity ($\beta = 0.052$, *p* = .041).

Team member attachment
Compositional effects – higher scores were found in teams with a higher proportion of nursing staff ($\beta = 0.499$, *p* = .020).

Diversity effects – higher attachment was found in teams with higher age diversity ($\beta = 0.682$, *p* = .042) and with higher occupational group diversity ($\beta = 0.072$, *p* = .008).

Effectiveness (ATPI scale)
Compositional effects – higher scores were found in teams with lower average tenure ($\beta = -0.059$, *p* = .015), and with a higher proportion of psychiatrists or other medical staff ($\beta = 1.057$, *p* = .047).

Diversity effects – higher scores were found in teams with a greater diversity of tenure ($\beta = 0.015$, *p* = .041).

Inter-team relationships
Compositional effects – higher scores were found in teams with a lower average tenure ($\beta = -0.042$, *p* = .021), and with a higher proportion of administrative/clerical staff ($\beta = 1.016$, *p* = .006).

Diversity effects – greater age diversity ($\beta = 0.936$, *p* = .002) was associated with better inter-team relationships, as was higher tenure diversity ($\beta = 0.011$, *p* = .047).

Team innovation
Compositional effects – higher scores were found in teams with a higher proportion of administrative/clerical staff ($\beta = 0.927$, *p* = .013).

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Diversity effects – there was no evidence of any effects of team diversity on team innovation.

Summary of compositional and diversity effects

A range of different effects were found here: many can be explained intuitively, although some are more confusing. The interpretation of these effects should be treated with some caution, for two main reasons. First, the models used to test the effects had comparatively low statistical power. One reason for this is the large number of variables included (19 of which were dummy variables for Trust and team type). Also, diversity effects are always difficult to detect on small samples when diversity indices are usually correlated with the main effects that are also included in the models. This means the tests are very conservative in nature, and gives greater credence to those effects that were found to be significant.

On the other hand, the data used for this analysis comprise only those individuals who responded to the questionnaire. Although the overall response rate was good, it was lower in some teams than others. In some teams fewer than 50% of team members provided data (and in a handful of cases well below 50%, although all met Dawson's [80] selection criteria for reliability of incomplete data). Unfortunately, due to restrictions of the data collection methods and the requirements for ethics committee approval, we were unable to obtain equivalent information for non-respondents. Whilst the estimated team scores for scale scores (e. g., climate, effectiveness) can be thought of as reliable with this number of respondents, it is not necessarily the case that demographic and diversity variables can [80]. Therefore it remains possible that the effects seen reflect characteristics of those people most likely to respond to a questionnaire than the whole team.

It is also possible, of course, that there exist differences in response due to professional group alone – e.g. that nurses are more likely to respond positively (or negatively) than another group. Although there is no a priori reason to expect this, and test of the individual responses do not reveal significant effects once the control variables have been taken into account, it suggests compositional effects should be treated with caution.

Nevertheless, there are some interesting patterns to emerge from the analysis. Overall there are no significant compositional or diversity effects on the main CMHT effectiveness score; however, when this is broken down into its component parts, and other outcomes examined, some relationships are found. The makeup of a team in terms of its occupational group provided some effects: a higher proportion of nurses was associated with perceptions of improved service user well-being, creative problem solving, team member satisfaction and attachment. More psychiatrists was associated with higher improved service user well-being, therapeutic relationships with service users, and feedback about effectiveness. More social workers was associated with better continuous care, while a higher proportion of administrative/clerical staff was related to creative problem-solving, better inter-team relationships and team innovation. Relatively few main

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effects were found for the other demographic variables, although team tenure and more female staff were associated with better responsiveness to carers, and team tenure was also associated with lower feedback about effectiveness and poorer inter-team relationships.

Few significant diversity effects existed, and most of those that were found involved age. Higher age diversity was associated with greater respect between professionals, higher team member satisfaction and attachment, as well as better inter-team relationships. This suggests that having a more age diverse team may be associated with better interpersonal relationships both within and outside the team.

3.4 Conclusions

Descriptively, there were clear differences between types of team, and these differences were relatively consistent across inputs, processes and outputs. Early intervention and assertive outreach teams generally scored the highest, with generic CMHTs scoring the lowest. Likely reasons for this are discussed in Chapter 5, when results of the qualitative research from Stage 3 are also included; however, it is clear that the team task plays a key role in this.

Although there are relationships between many of the dimensions examined and effectiveness, use of relative importance analysis shows which of these were the most critical in predicting good team performance. Overall, creativity was the strongest predictor of effectiveness: teams which allow for greater degrees of creative problem solving to be shown by members generally performed better than others. An absence of conflict from teams was another important factor here, as was the process of allowing all members to participate appropriately in decision making. Having the right inputs into the team was also important: the right mix of skills and a high level of effort lead to more effective teams, as does having well-designed work (incorporating autonomy, task relevance, a complete task, feedback and interdependence amongst team members). These findings were independent of differences between team types, but are even further illustrated by the fact that those team types designed with the clearest task (Early Intervention and Assertive Outreach teams) were those with the best results according to the survey.

There was also clear support for the input-process-output model; that is, the reason that task design, and team effort and skills, were predictors of effectiveness was that these effects were mediated by certain team processes – namely creativity and participation. Teams that have the best inputs are likely to have the right conditions to allow creativity to flourish, and the set-up to enable team members to participate accordingly (e. g., shared caseloads, effective meetings). This is explored further in Chapter 4.

Although there was generally consistency of these results across different team types, there were still some illuminating differences. These were most prominent in the importance of team inputs. The levels of organisational support, and resources, available to teams were not as important for the more specialist team types, although this may be because the levels of support and resources in these teams were uniformly higher (and therefore there were no "weaker" teams to provide the variation for such a finding). However, for generic CMHTs, organisational support was far more important for effectiveness. For older adult CMHTs, the resources available were the most important predictor. It may be that in these teams, the absence of resources or support is more likely to be felt, or that there is just a greater range within our sample. Across the board, organisational support is an important predictor of inter-team working, which is one of the more important aspects in delivering effective care pathways [9, 41].

As well as the right mix of team members in terms of skills and background (which was not only indicated by the ATPI scale "team effort and skills", but also by examining the differences in professional background of respondents), there were also a few demographic effects. Notably, teams with a greater diversity of age tended to be more effective across a range of dimensions.

In summary, from both the team type analysis and the model testing, it is clear that teams with a clearer, more focussed task design and composition (including team effort and skills) are those that are the most effective. This appears to be (at least in part) because they enable greater levels of participation in decision making, and more creative approaches to working.

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4 Chapter 4: Stage 3 (Qualitative Study of 19 teams)

Chapter Summary

This chapter describes the qualitative analysis undertaken with 19 teams drawn from five trusts in Stage 2 of the research. The purpose of this qualitative stage of the project was to identify the fine-grained team processes, and contextual, professional and institutional incentives and barriers to effective MPTW in CMHTs. Due to its lengthy nature, the chapter is summarised over these next four pages.

In each team, researchers observed a weekly team meeting, and interviewed a selection of team members and (usually) service users and carers in order to discover team factors that enabled, or hindered, the teams in relation to the seven domains of team effectiveness identified in Stage 1 of the research. Two semi-structured interview guides were developed, one for service providers and one for service users and carers, to take account of their different perspectives on the work of the team. These guides were based on the themes of team effectiveness in mental health care distilled from the Stage 1 workshops.

The data included observation of 20 team meetings, and interviews with a total of 114 service providers (including 4 consultant psychiatrists or associate specialists, 44 CPNs, 8 OTs, 6 clinical psychologists, 15 social workers, 14 support workers, 4 managers, 4 junior or staff doctors, 11 administrators and 4 'other'), 31 service users and 13 carers. Two of the teams were generic Adult CMHTs, five were AO teams, six were R&R teams, two were EI teams, two were Substance Misuse teams, one was a CRHT, and one was an Older Adult CMHT.

We analysed the interview and team meeting observation data using the principles of grounded theory, a systematic procedure for developing theory that is 'grounded' in the data as they emerge. As the data were collected they were compared with previous data to identify similarities and differences in the concepts and categories, which were developed through the coding process. The findings summarised below offer a novel and rich picture of the processes and experiences of CMHTs from the perspective of the key constituencies of those teams.

Observation of team meetings

The purposes of most of the meetings appeared to be routine and, therefore were understood implicitly by team members. Only in a handful of instances were written agendas used. Most meetings focussed on service-users' care and 'case management' issues e.g. reporting/communicating developments; reviewing day-to-day care; planning contact; assessing risk; problem-solving;

reviewing referrals; giving feedback on assessments; reviewing and approving care plans. Meetings were generally characterised by light-touch chairing/facilitation and free-flowing interactions to which many individuals contributed. Despite light-touch chairing, most meetings were orderly with understanding shown between participants about who 'had the floor'. In a small number, however, there were instances of participants talking over or interrupting one another, or conducting more than one discussion.

Strong inter-personal positivity was displayed in nearly all the observed meetings. There was much good humour and good-natured and well-received teasing, and a lot of smiles and laughter. There was evidence of psychological safety in members' willingness to contribute to discussions in most meetings and to express alternative viewpoints.

A reflective approach to team tasks and processes was evident in most of the team meetings observed. The extent to which this was present, however, was dependent on a number of factors, including the purpose and focus of the meeting, the time available in relation to the meeting task, the team members attending and the model of mental health care predominating in the team.

The meetings offered abundant evidence of role interdependence within teams. In the majority of instances, it was clear from discussion that a service-user's care was being delivered by a sub-group of the team. The smallest 'delivery unit' was two members (most often a care co-ordinator and a doctor); in many instances many more team members would be involved, particularly in Assertive Outreach teams.

Findings from interviews
In articulating the major goal of their team, improved service user well-being was of key importance to almost all teams and their members. Some participants used this specific term, although the terms 'increased quality of life', 'independence' and 'recovery' were also common elements of teams' goals, as was the notion that there is no absolute perspective on 'recovery' or, indeed, 'well-being'. Reduction of hospital admissions was also a recurring theme. Service users and carers also saw improved service user well-being as the main goal of the team, although understandably they focussed generally on the specific goals of their own care or their service user's care. Service user involvement in care planning was generally presented by participants as standard practice, although a number of hindrances to this were identified.

Several interviewees (mainly from EI teams) indicated that their team had relatively good resources and was, therefore, able to exercise greater creativity than might be found elsewhere in community mental health services. Others pointed to team efforts to provide 'space' by making best use of their resources through mechanisms that limited or cleared case-loads or enabled prompt discharge of service users when appropriate. Many mentioned seeking out appropriate external resources, principally in the not-for-profit sector. However, many participants pointed to lack of internal resources, both staff time and

financial resources, as limiting their team's ability to be creative in the ways they delivered care for service users.

Overall, service users and carers were positive about their experience of their team with regard to continuous care. Communication between service users and carers and teams was generally effectively maintained but participants did identify instances of broken continuity, usually when a service provider was unexpectedly absent from work.

Lack of stability and continuity in team membership was also mentioned frequently. Issues raised included the four-to six-monthly turnover of psychiatric trainees, consultant psychiatrist posts being filled by locums, inability to appoint locums to other posts, staff being appointed on temporary contracts, loss of team members through restructuring and early retirement, and poor induction of new staff due to rapid turnover.

Referral processes were identified by some service providers as having a major bearing on inter-team working. The potential for referral processes to be the locus of poor working relationships with other teams because of lack of agreement about responsibility for providing a service, restrictive service criteria, inflexibility on the part of other teams or inappropriate referrals from other agencies was mentioned by a number of participants. Some also referred to the difficulty of maintaining continuity of communication when services were reorganised. Participants saw the restrictiveness of referral criteria as central to the effectiveness of referral processes along with inadequate team and Trust resources. Referrals could be a source of friction, but there was recognition that seeking mutual understanding, negotiation and reciprocity was essential for the maintenance of positive relationships with other teams and agencies. In some cases there were indications that simply managing the expectations of other teams, and maintaining the flow of information, would be sufficient to sustain positive relationships.

Inter-professional respect was good in most teams and was a result of team members' shared commitment to the care of service users. It was enhanced further in team environments where there were opportunities to use members' specialist and generic skills, decision making processes were open and flexible, there was a culture of inclusiveness and there was not too much managerial pressure on the team. Mutual learning between team members was enabled when there were many formal and informal opportunities for team members to 'converse'.

Generally, participating teams and team members had positive and valuing attitudes towards carers although some said that engaging with carers could present challenges. Having access to professional training or experiences that promote positive carer attitudes were the principal factors enabling responsiveness to carers as well as the establishment of carer-specific services within the team. Leadership in relation to responsiveness to carers was important

while a lack of service user inclination to engage with providers, and lack of team resources, were both seen as impeding responsiveness to carers.

In general, the establishment and maintenance of therapeutic relationships between service providers and service users was seen by participants as central to the work of the teams. Collaborative working between service providers and service users was depicted as not only a matter of good team practice, but as indicative of a team ethos of high quality care. Openness and honesty appeared to be a more difficult aspect of the therapeutic relationship to sustain. Here the main challenges identified by service providers related primarily to the level of insight service users have about their mental health and the need to balance honesty with the overall aim of maintaining a therapeutic relationship.

Conclusions

Three themes predominated in the data. First, the clarity of the team task was an important factor influencing teams' performance. Teams that had less clear tasks (and less clearly defined service user populations) displayed less focus and less effectiveness. Second, the quality of communication was also key, including not only intra-team communication, but also communication with other CMHTs, other agencies, and also with service users and carers directly.

Third, a recurring feature influencing teams' abilities to deliver care was resources available to the team. This included staff availability (both in bodies available and workload), and was closely linked to the reorganisations that many teams were experiencing and that had led to reductions in resources. This was apparent not only to service providers, but to service users and carers also and led members of all these constituencies to doubt the institutional commitment to mental health care.

4.1 Background and aim

The purpose of this qualitative stage of the project was to identify the fine-grained team processes, and contextual, professional and institutional incentives and barriers to effective MPTW in CMHTs. From the perspectives of service providers and their service users and carers in our selected CMHTs we hoped to elicit their detailed accounts of how effective the teams are in delivering high quality mental health care for their users.

4.2 Selection and recruitment of Trusts

From the 11 Trusts involved in Stage 2 of the project, five were invited to participate in Stage 3. The selection was based partly on the Trusts' urban and rural mix but also on how successful recruitment at earlier stages had been in

the Trusts, to minimise any probability of the project being delayed because of difficulties with recruitment.

Using the UK Government Office regions [81] the selected Trusts represent the East of England, (predominantly rural with some major urban centres), the East and West Midlands, (including two of England's major cities both with high proportions of BME people), and the South of England (South of London), which includes some mid-sized urban centres.

From these Trusts we hoped to recruit 20 CMHTs which had completed the Stage 2 questionnaire and for which the ATPI team reports were available to us, and which together represented, as far as possible, the different types of CMHTs in the study. On the basis of the Stage 2 ATPI team reports we planned to recruit 10 high- and 10 low-performing teams.

4.3 Ethics and Research Governance approval

The application to proceed with data collection for this stage of the project for the five selected Trusts during the period from 1st February to 31st July 2011 was submitted to the Birmingham East, North & Solihull REC on 14th June 2010, which notified us of its favourable opinion on 28th July 2010.

Some further delays were met, however, in the research governance approval process; this is described in more detail in Appendix 1.

4.4 Methods

4.4.1 Design
The study used the qualitative methods of individual semi-structured interviews and with service providers, users and carers, and observations of team meetings.

4.4.2 Selection and recruitment of CMHTs
At the end of November 2010 when the Stage 2 data collection phase was almost completed, one of the authors (JR) selected 44 CMHTS representing a wide variety of types and each of the selected Trusts. From this pool of CMHTs JR selected the 10 highest- and 10 lowest-performing teams as revealed by analysis of the ATPI data; it was anticipated that the potential 80+ individual interviews and 10 team meeting observations conducted for each sub-sample would be sufficient to ensure a form of data-saturation (see section 4.6.3). The teams were invited by e-mail dated 24th November 2010 to participate in the study (see Appendix 2). This REC-approved letter provides comprehensive information about the project, including carefully explaining that each participating team's Stage 2 report would be withheld until after data from Stage 3 had been collected. The researchers who were involved in almost all of the data collection (GH & PBN) were blinded to each participating team's report and its ATPI

identified high- or low-performing status until after data had been collected from the team. These measures were adopted to ensure that the researchers who visited teams to gather data did so with no preconceptions about the teams' performances.

At about the same time as the letters of invitation were posted out the CSOs in our selected Trusts were informed of our selection of teams and provided with copies of the invitation letter and asked to help us in recruiting the nominated teams.

It quickly became clear early in 2011 that the recruitment of all of our selected teams was not going to be as straightforward as we had anticipated. There are a number of possible reasons for this. Probably the most important reason was that in most of our selected Trusts, community mental health services were undergoing significant re-organisation, largely it seems in response to cuts in budgets. A few teams declined the invitation to participate in this study because of current or pending reorganisations. We therefore needed to invite other Stage 2 team leaders from our pool of 44 teams to participate. Of course, doing so means that the final sample of teams from which data have been gathered does not consist of such clearly defined high- and low-performing subgroups as we had intended and our intention of making comparisons between these in analysis could not be fully realised. In addition, although we did believe we had recruited 20 teams to this stage, two had merged with each other by the time of the fieldwork meaning that our final sample was 19 teams.

In summary, despite the persistent and invaluable help of Trust CSOs, the recruitment process was very slow with our last visit to a team being made on 25th-26th July, a few days before our ethical approval expired.

4.4.3 Procedures

As the Letter of Information that we sent to team leaders shows (Appendix 3), for each team we requested (up to) 45-minute one-to-one interviews with three to six members of the team (preferably including one team member from each major professional group) and with three of the team's service users or carers (with at least one of each). Potential team member interviewees were supplied with the REC approved Information Sheet and Consent Form (Appendix 3) by their team leader. The team leader was also asked to identify and recruit suitable service users and carers on our behalf using the REC approved Information Sheet and Consent Form supplied by us (Appendix 4). We informed participants that all interviews would be conducted by a member of the research team and we requested that all interviews would take place on Trust premises. We also requested that a researcher should observe a team meeting. We adopted the strategy of interviewing and observation so that we might triangulate the data from these two methods and therefore make our findings more robust than if we had used only one of these methods.

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4.4.4 Sample

As noted above, data were collected from 19 teams in total across five Trusts. This included observation of 20 team meetings, and interviews with a total of 114 service providers (including 4 consultant psychiatrists or consultant specialists, 44 CPNs, 8 OTs, 6 clinical psychologists, 15 social workers, 14 support workers, 4 managers, 4 junior or staff doctors, 11 administrators and 4 'other'), 31 service users and 13 carers. Two of the teams were generic Adult CMHTs, five were AO teams, six were R&R teams (one of which also included AO services), two were EI teams, two were Substance Misuse teams, one was a CRHT, and one was an Older Adult CMHT. A summary of the groups interviewed per team is given in Appendix 8.

There were very wide differences in participating teams in terms of the range and balance of professional roles they incorporated. Generally, nurses predominated, with occupational therapists and social workers less evident. The exact relationship of the latter to the Trust, and, therefore, the team was variable, and they often also had a Trust-wide Approved Mental Health Professional role. The care co-ordination role within teams was generally undertaken by staff with one of these three professional backgrounds; nurses usually had a care co-ordination role, although we encountered a couple of teams in which there were coordinating social workers or occupational therapists. Some teams incorporated a clinical psychologist (or, had, at least, dedicated clinical psychology hours); some could only refer to a centralised service. The time commitment of consultant psychiatrists and other doctors in the teams was also variable.

All the teams, except for the Substance Misuse teams, had a dedicated consultant psychiatrist, but their integration within teams ranged from fully embedded (full-time and based in the team room) to 'semi-detached' (some dedicated part-time hours and based in another building). Some teams also had junior psychiatric medical staff attached, while substance misuse teams did not have psychiatrists, but specialist doctors. There was also considerable variation between the teams in the ratio of professionally qualified team members to support workers and a few support workers had specific roles (e. g., housing support; carer support), but most worked generically. Variation was also apparent in how far administrative staff were integrated into teams; this was evidenced particularly in whether they participated in clinical team meetings and the nature of their participation.

The management and leadership of participating teams also varied considerably. As indicated above (p. 66), most of the participating teams had recently experienced, were currently experiencing, or were soon expecting to experience reorganisation or restructuring. One team was to be disbanded at the end of the month following our visit; another had only been in existence in its present form for two weeks when we visited. There had been loss of personnel in many teams and re-grading of staff in others (and some teams had experienced both). Most

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often, Trust restructuring had resulted in changes to the management of teams and in the participating teams there was variation in management models, some of them very new to the team. Individuals with day-to-day operational responsibility were variously called 'team managers', 'team leaders', 'clinical team leaders' and 'team co-ordinators'. While team managers were usually responsible for more than one team (either two or three) and were rarely care co-ordinators, team leaders etc. invariably had care co-ordination responsibilities. Most individuals in management or leadership posts had a background in nursing, although some had social work or occupational therapy qualifications.

The role of consultant psychiatrists and other consultant doctors in respect of team leadership was variable and sometimes ambiguous. While none had formal leadership responsibility in any of the teams, a few were very prominent in clinical leadership; in one team the role assumed was as clear clinical leader, while in another joint clinical leadership with the team manager appeared to be in operation (and in this instance both also had limited care co-ordination responsibilities). Many doctors we encountered had a holistic approach to their care of service-users, but some appeared to concern themselves almost exclusively with diagnosis, medication and risk assessment.

The service users and carers interviewed were identified by the team leaders, and were therefore not necessarily a representative sample. Very few of the service users who participated in the interviews had family members or friends they had identified as carers. Where there were carers these were often the parents of a young person or the spouse of an older adult with organic impairment and the service user was rarely able to comment beyond confirming their awareness that the team had some interaction with their carer.

4.5 Instruments

4.5.1 Interview schedules

Following discussion in separate meetings of the project's co-investigators and of our User and Carer Advisory Group, we developed in-depth semi-structured schedules for researcher use in one-to-one interviews. Bearing in mind that interviews are "conversations with a purpose" [82, 83] and that our purpose was to reveal our participants' feelings, perceptions and experiences of the sensitive topic of teamwork, we chose to use individual interviews. It was felt that alternatives, for example, focus group discussions may have inhibited our participants' authentic reflections on the team.

Two semi-structured interview guides were developed [84], one for the service providers and one for the service users and carers, to take account of their

different perspectives on the work of the team. After the first three visits to teams, the researchers met to discuss the guides, resulting in some minor adjustments, primarily concerning the ordering of the interview themes. The final versions of the guides are in Appendices 6 and 7. These guides strongly relate to the themes of effectiveness in mental health care distilled from the Stage 1 workshops. In addition to these themes the major new theme of "Organisational context" was added to enable exploration of the impact of any organisational changes which had occurred during the previous 12 months or so. The intention here was to draw out issues of team leadership, the resources of teams, including the adequacy of the mix of professional groups represented in them, their capacity to respond to the demands placed on them and the different expectations of their Trusts, and the extent to which they are met. In addition, relevant team-specific or role-specific themes that emerged in the course of interviewing were explored.

4.5.2 Recording of observation of team meetings

The sheet for recording observations of team meetings (for pencil-and paper completion by researchers) is shown in Appendix 9. We elected not to audio-record these meetings because we envisaged significant difficulty in obtaining ethical approval to do so, and even had such approval been obtained we may have had difficulties in obtaining the consent of all members of the team.

As the recording sheet shows, the focus of the observations was to see the team in action as a team, to observe processes that may impact, positively and negatively, on service user care. Specifically, the observation sheet focuses on issues of team working including leadership (including clarity of the purpose of the meeting), communication and decision making, reflexivity, role interdependence and inter-personal positivity.

Every effort was made to minimise researcher-effect, however the researchers had little control over the observation environment and the outcomes were variable. The familiarity of team members with the researcher observing the meeting varied from team to team. In some instances the first encounter of any kind any team member had with the researcher was in the observed meeting; in some, there had been prior email and/or telephone contact between a team member/s (e.g. team leader, administrator) before the visit and some familiarity had been established; in some, one or more interviews with team members had already been conducted before the meeting, so that some participants were more familiar with the researcher than others; and so on.

Researchers attempted to play no active part in the meeting. In some instances the researcher was invited to introduce themselves and/or say a little about the research before the meeting commenced; some teams introduced the participating members to the researcher. How far the researchers were able to maintain a physical separation between themselves and the meeting participants

varied, depending on the venue for the meeting and the seating arrangements; wherever possible, researchers positioned themselves so that full observation (including body language) could be achieved while non-participation in the proceedings was clearly established. On a few occasions it was difficult to maintain total passive non-participation when, for example, a team member chose to address a remark to the researcher or, more often, the researcher spontaneously reacted to the almost invariable humour displayed by team members during the meetings.

Observation notes, including verbatim quotes, were recorded during the meetings and reviewed and, where appropriate, supplemented shortly afterwards.

4.5.3 Transcription of interview recordings

Meeting observation notes were typed up by the research team administrator.

The digital audio-recordings were transcribed by an external transcription service. A researcher randomly selected two of the transcriptions and compared these with the audio-recordings. These comparisons suggested that the transcriptions were accurate and reliable and so no further comparisons were made.

4.6 Data Analysis

4.6.1 Background and key decisions

We analysed the interview and team meeting observation data using the principles of grounded theory [85], a systematic procedure for developing theory that is 'grounded' in the data as they emerge [86].

The focus of grounded theory is incidents and not people. The approach tries to identify the main concerns of the participants in the incidents, how they approach and react to them, and how they interpret them. Grounded theory uses both inductive and deductive reasoning as theoretical propositions are generated and tested out in succeeding episodes of data gathering and data analysis. Inductive reasoning is used during the conceptualisation of data and deductive reasoning during the process of making linkages between conceptual labels, subcategories and categories [87]. The concepts of grounded theory include theoretical sampling and data saturation [88].

Theoretical sampling "is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory

as it emerges" [85]. The purpose of gathering data on the basis of emerging concepts is to increase the opportunities of identifying the variations among concepts and to "… densify the categories in terms of their properties and dimensions" [86]. In our case the initial emerging concepts and categories are those we derived from Stage 1 of the project (see above), which became the major themes of the interviews in Stage 3, supplemented by the theme of 'organisational context' and any relevant case specific themes (see section 4.5.1). As data gathering progressed, greater emphasis was placed on those concepts and categories that began to emerge as central or where greater clarity was needed.

Another key concept of grounded theory is constant comparison. Of constant comparison Teshc [89] says:

> "The method of comparing and contrasting is used for practically all intellectual tasks during analysis: forming categories, establishing the boundaries of the categories, assigning the segments to categories, summarizing the content of each category, finding negative evidence etc. the goal is to discern conceptual similarities, to refine the discriminative power of categories, and to discover pattern."

We have used these principles of constant comparison throughout our data collection and analysis. As the data were collected they were compared with previous data to identify similarities and differences in the concepts and categories, which were developed through the coding process. Coding of the transcriptions of the interview audio-recordings was facilitated by using NVivo 8, a qualitative data analysis software package. Coding consisted of three stages: open coding; axial coding; and selective coding. In open coding, the data were fragmented into first level open codes (child nodes in the language of NVivo). Codes on a common theme were then gathered to form higher level categories (axial coding, tree nodes in NVivo language). In essence, the stages of open and axial coding were largely completed with the identification of the Stage 1 themes (see above), which subsequently became the major themes of the Stage 3 interviews, although new themes, such as "Organisational context" (see above), were added as they emerged from the data. The codes that were used, including those developed in the constant comparative analysis, are shown in Appendix 10.

4.6.2 Memoing

Throughout the process of collecting and analysing data the field researchers (JD, GH, PBN & JL) have been 'memoing', that is, note-making to record thoughts and ideas as they have occurred throughout data collection and data analysis. Sometimes these thoughts and ideas have emerged from discussions in formal meetings and sometimes through less formal conversations between researchers, and sometimes even in the minds of individual researchers. In all of these ways we have had an "internal dialogue with the data" [87].

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4.6.3 Theoretical saturation

In principle in grounded theory research, further data collection decisions should be made on the basis of developing categories and concepts until theoretical saturation is achieved. Saturation is the point at which new cases add no new information for existing categories [90] and suggest that no new ones should be created. This is the point at which further data collection is stopped. In the case of the present study however, the decisions about the sample size and characteristics of the teams were made during the process of writing the project funding application, and therefore the principle of theoretical saturation in its classic form was not adhered to. Nevertheless, the researchers noted that relatively few new insights appeared to be gained in the latter interviews and observations; this assessment was confirmed during analysis.

4.7 Observation of team meetings

4.7.1 General

The team meetings we observed varied in their exact purpose, frequency (although most were weekly meetings) and duration. This can be largely accounted for by the variation in team task and model of case-load responsibility in the teams that participated.

Most of the meetings were chaired/facilitated by the team manager/leader/co-ordinator. Two were chaired by a consultant doctor, who in each case was deputising for the team manager. In two instances the meetings were chaired on a rotating basis by team members. In one instance it was difficult to discern who was taking this role, however this was a team that had only been in existence in its present form for two weeks and it was clear that team processes were in a transitional state.

4.7.2 Clarity of purpose

The purpose of most of the meetings appeared to be routine and, therefore, understood implicitly by team members. Only in a handful of instances was a written agenda used and even in instances where the purpose of the meeting was not routine, or where agenda items invited non-routine contributions, there was scant use of written agenda. In most instances where there was a written agenda, this was in possession of and referred to only by the person chairing/facilitating the meeting, apparently as an *aide memoire* about the routine matters the meeting should be covering.

Most meetings focussed on service-users' care and 'case management' issues of one kind or another (e.g. reporting/communicating developments; reviewing

day-to-day care; planning contact; assessing risk; problem-solving; reviewing referrals; giving feedback on assessments; reviewing and approving a care plan). Some served more than one purpose, addressing team management issues as well. Only one was concerned exclusively with the latter.

A variety of resources were employed in the conduct of the meetings, varying in relation to the nature of the team task and exact purpose of the meeting. These included: message book; team diary; print-out of team case-load; board listing all service-users (with or without 'traffic-light' system) and annotated with contact/action agreed; projected copy of a care plan.

Again there was variation in how proceedings and decisions were recorded, although, in most instances, minutes/notes were taken by an administrator. There were few examples, however, of reference to the minutes/notes of previous meetings.

4.7.3 Communication

Most meetings were characterised by light-touch chairing/facilitation and free-flowing interactions to which many individuals contributed. This was particularly marked when the discussion concerned aspects of the care of an individual service-user and team members had the opportunity to contribute from their knowledge of the particular service-user or from relevant professional/clinical knowledge. In the meetings observed where the chair rotated, it was notable that the individual in that role confined her activity to steering the agenda, rather than adopting a role that facilitated communication.

There were no instances where all of the participation was stilted or forced, although there were some meetings where some individuals contributed little or nothing. There were a small number of meetings where most of the interaction/communication was between the chair and individual team members, with little or no spontaneous communication between attendees. These teams differed considerably in several of their characteristics, although two were the only Substance Misuse teams observed and two were the only ones chaired by consultant doctors.

In general, team meeting participants appeared to understand the contributions made by one another without need to seek clarification about meanings. There were instances where further information was requested, but most contributions were straightforward provisions of information or expressions of opinions or viewpoints.

Despite light-touch chairing, most meetings proceeded in an orderly way with understanding shown between participants about who 'had the floor', however, there were instances of participants talking over or interrupting one another, or conducting more than one discussion. One of these meetings was dominated by

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the team manager, who was chairing; not only did members talk over each other and conduct parallel discussions, but the chair talked over others on occasion.

4.7.4 Decision making

Since most of the meetings observed were wholly or largely concerned with individual service-user care, the majority of decisions that had to be made through them also had this focus. In these instances, as some teams (particularly AO teams) adhered in principle or practice to the notion of a team case-load, decisions were, in theory at least, to be made jointly in these teams. This was invariably accomplished following discussion between any members who felt they could usefully contribute. Often these discussions were steered or facilitated by a senior member of the team (see below under 'Leadership').

It was not always clear when or if a decision had been reached and team managers were proactive on occasion to bring the discussion to the point of decision making, as the following questions that were posed indicate:

> *"What actually am I doing with him?" (re: an inappropriate referral)*

> *"Right, so let's make a decision. Can we do it, or not?"*

4.7.5 Inter-personal positivity

Strong inter-personal positivity was displayed in nearly all the observed meetings. There were humour and jokes (sometimes running jokes), good-natured and well-received teasing, and a lot of smiles and laughter. There was evidence of psychological safety in members' willingness to contribute to discussions in most meetings and to express alternative viewpoints.

The extent to which members gave praise, thanks, positive feed-back and support to one another is notable. This related most often to work that had been accomplished or a contribution to the meeting/discussion. Comments such as the following were frequent:

> *"Excellent. Excellent. Very well put."*

> *"X did me a big favour. I meant to bring you a bar of chocolate..."*

> *"That's impressive – how did you manage that?"*

> *"That's what I call service, well done"*

> *"She needs a round of applause"*

Such inter-personal validation was most often given by more 'senior' team members to more 'junior' team members, that is by team managers/leaders or consultant doctors to others or by care co-ordinators to support workers or administrators. However, it was also displayed between peers on occasion and also occasionally towards managers; an example of the latter related to a team

manager who had succeeded in effecting a case transfer protocol with another team after many months of dispute. There were also instances of managers thanking the whole team for their work.

There were very few observed instances of inter-personal negativity; these were predominantly mild and could be attributed to professional rather than personal differences.

4.7.6 Leadership

Predominantly leadership in the meetings was taken by team managers/ leaders/co-ordinators and/or by senior doctors. However, senior doctors' leadership was mainly confined to issues of risk assessment, diagnosis and medication, while team managers' tended to relate to all aspects of the teams' work and organisation. In the case of team managers, leadership was combined in the majority of instances with chairing/facilitating the meeting.

The range of leadership activity undertaken by managers in the meetings included: information-sharing; facilitating discussions by questioning, challenging, clarifying, making suggestions; drawing in participants to elicit knowledge or expertise; inviting reflection; requesting volunteers for work or asking particular team members to undertake tasks; problem-solving; guiding and pressing for decisions.

In discussions about individual service-users' care, care co-ordinators would most often take the lead in relation to their own cases. However this role would be filled by any team member who was working with the service-user in the absence of the care co-ordinator. It was rare in the observed meetings for team members to take a leading role on items that were not concerned with individual service-users, although there were some instances of non-clinical issues being raised by individual team members (for example, in the "Any Other Business" section of a team business meeting). Different patterns may have been evident had different sorts of meetings been observed.

4.7.7 Reflexivity

Reflexive behaviour, and the extent to which it is central to team processes, is an indication of a group's focus on examining their practice, both individual and collective, to enhance service user care.

A reflective approach to team tasks and processes was evident in most of the team meetings observed. The extent to which this was present, however, was dependent on a number of factors, including the purpose and focus of the meeting, the time available in relation to the meeting task, the team members attending and the model of mental health care predominating in the team. Team task appears less central.

The extent to which individual team members in a meeting participated in reflective discussion also varied depending on their team roles (and, by inference, their training and experience) and their role in relation to the meeting. Most frequently, however, team managers/ leaders and/or senior clinicians (e.g., consultant psychiatrists) were the generators of reflective discussion or comment, indicating that this is a primary characteristic of leadership in this setting.

Invitations to reflect were frequently made by posing questions to the meeting as a whole. Often these were focused on the general involvement of the team in a service-user's care. Questions were also occasionally posed about specific aspects of the care being offered a service-user. These were most often directed to a specific team member, so that reflection on an individual's practice was sometimes conducted in open forum.

In addition, team meetings were often the forums in which risk assessments of service-users were conducted and decisions made about action relating to risk. Again, teams were invited to reflect through the posing of questions, for example:

> *"Shall we say that, until further experience, two people should visit?"*

Sometimes a similar approach to generating reflection on aspects of the team's work not related to an individual service user's care was adopted:

> *"I don't think we have the same relationship with Substance Misuse as we used to, do you?"*

> *"So where do we stand with the referral criteria?"*

Further evidence of reflexivity was observed in some of the statements made by team members about their involvement in the care of service-users. The openness of such statements was an indication, where it occurred, of the psychological safety felt by individuals within their team:

> *"I'm at a loss with this family."*

> *"I did wonder whether there was a degree of depression, but I'm not sure ..."*

4.7.8 Role interdependence

The meetings offered abundant evidence of role interdependence within teams. In the majority of instances, it was clear from discussion that a service-user's care was being delivered by a sub-group of the team. The smallest 'delivery unit' was two members (most often a care co-ordinator and a doctor); in many instances many more team members would be involved, particularly in Assertive Outreach teams.

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However, role-interdependence was also evident in the participation in care discussions and decision making undertaken in team meetings. Here several members of a team might contribute both from their knowledge of a particular service-user and/or from their professional knowledge and expertise, offering insight or guidance to their colleagues about specific aspects of a service-user's care. Consultant psychiatrists and social workers, in particular, were observed to provide a consultative role to colleagues.

4.7.9 Attendance and interruptions

Team members were expected to attend each of the observed meetings unless other work commitments took precedence (such as an emergency concerning a service-user). It was evident in a small number of instances that members who were expected to be present had not attended and it was often the case that the reason for this was unknown; in relation to the unexpected absence of a consultant psychiatrist, one team manager asked "Where is X today? I wonder if he's avoiding us."

Most CMHT members have mobile phones exclusively for use in relation to their work. It was evident in the meetings that there is a high level of tolerance and trust about the use of these. There were several observed instances of phones ringing during meetings and the team member leaving the room to answer it; on a couple of occasions the team member did not return to the meeting. Interruptions were also observed whereby a team member was called out of the meeting by an administrator or other team member.

4.7.10 Physical environment

Predominantly, the observed meetings were held in rooms that were suitable for the purpose, in that they provided sufficient space and seating for all present. Most were conducted in rooms used specifically for meetings. In a couple of instances, however, meetings were held in the team office and while this ensured sufficient seats, the layout of the rooms meant that some participants were seated in the centre of a circle formed by the rest. In one other instance the meeting was held in a room where there were insufficient seats for all those participating and some were required to sit on the floor. In another instance, there was so much noise from the road outside that it was difficult for participants to hear one another.

4.8 Findings from interviews

This section focuses on the seven dimensions of effectiveness as derived from the Stage 1 workshops. For each, some general observations made by the interviewees are described, as well as the enablers and barriers that were

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identified. These are illustrated by some direct quotes from the interviews (a key to abbreviations used in attributions of quotes is given in Appendix 11); largely these are from the team members as opposed to service users and carers as the latter groups were often unable to give much insight into the factors enabling effectiveness, although their perspectives on the care provided were informative.

4.8.1 Improved service user well-being

Three broad issues were explored under this heading:
- Whether improved service user well-being is a major goal of the team
- How far the team assists service users to build positive aspects of their lives and move towards recovery
- The extent service users' views are taken into consideration, including in the care plan

The first part of this section explores how improved service user well-being and related concepts were viewed by participants as a goal of their teams; the second part examines what factors enable and hinder the successful formation of service user care plans.

Evidence presented in Section 4.7 reveals how the team meeting as a regular forum can help improve service user well-being by offering opportunities for multiple professionals to contribute to decisions made about care of individuals. This is probably the best example of direct links between team working and improved well-being, and is not repeated here. Most issues in this section were ultimately down to the relationships between service users, carers and individual team members[8].

In articulating the **major goal** of their team, improved service user well-being was of key importance. Some participants used this specific term, although the terms 'increased quality of life', 'independence' and 'recovery' were also common elements of participants' definitions, as was the notion that there is no absolute perspective on 'recovery' or, indeed, 'well-being'. Reduction of hospital admissions is also a recurring theme.

Service users and carers also saw this as the main goal of the team, although understandably they would also tend to focus on the specific goals of their own care or their service user's care. Where higher-level goals were articulated, this was often in terms of 'getting or keeping stable', 'coping with life', 'keeping well', 'having a better life' and similar. Service users and carers associated with substance misuse teams tended also to refer to abstinence from drugs or alcohol. The extent to which interviewees tended to see the goals of the team in

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[8] Due to the difficulty of disaggregating the concepts of 'taking service-users' views into consideration' and 'collaborative working with service-users' in the comments made by participants, generic findings relevant to the former are not presented here, but in the later section addressing therapeutic relationships with service-users. The issue of participation in care planning is addressed here, however.

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individual terms may be, in part, a reflection of their experience of the team as individual-service user focussed:

> *"They try and achieve recovery, sobriety, recovery, helping people understand their emotions and get back on their feet. Well, for me, its abstinence, personally, there's no other option. Some people might not be at that stage and they may need help with managing their drinking or drug use. I don't know. I can't speak for other people."* (SU; SM; J)

> *"Their goal I think is to help the service user cope with life and get involved in the community, you know, into paid work or unpaid work, whatever's appropriate and they also try and reduce the medication that they're having …"* (Carer; R&R; J)

Service providers' articulated goals often included elements that relate to the team remit, usually because this and the service user group is well-defined (that is in relation to Crisis Response and Home Treatment, Assertive Outreach, Early Intervention and, to some extent, Substance Misuse teams). In CRHTs, for example, preventing admission to hospital was dominant. In AOTs, engaging with reluctant service users to maintain their 'wellness' (through medication) and functioning in the community – sometimes to help them 'recover' or 'move on' – featured prominently. At least implicit in most definitions was the understanding that service users have enduring mental health problems that have and could lead to hospital admission if not closely monitored.

In the context of team goals, it was notable that some team managers and team leaders also talked in terms of the performance targets set by the Trust, although none did exclusively of other issues.

Whether the team had a well-defined service user group or not, the overall thrust of service providers' contributions relating to team goals indicate a dominant ethos of taking the lead from service users and going at the service users' pace to achieve a state of 'well-being' defined by the service user. Sometimes this includes eventual disengagement from mental health services (the issue of service user 'dependency' was discussed by some participants, and the intractability of some mental health problems acknowledged), but, more often, it means optimising the service user's functioning and quality of life in the community. Participants made numerous references to a holistic approach to service user care and encouraging whatever positive developments seem to be achievable. There is a very clear sense that this involves 'building positive aspects of service users' lives' wherever this is possible and trying to move towards some level of 'recovery'.

It was clear from participants' contributions that one of the major enablers of improving service user well-being was the joint formation of **care plans**. Most service users have such plans, although there were some exceptions among service users from CMHTs and substance misuse teams, depending on the terms of their involvement. By service providers' accounts, there appears to be a near-universal attempt to involve service users in formulating care plans. In the

interviews, however, some service users seemed to set very little store by their care plans and, where they confirmed they had one, some said they were unaware of its contents. Others were unclear whether they had one or not. It would be unwise to deduce anything concrete from this, however, as service users sometimes commented their memory was not good, often due to the medication they are taking.

One major barrier to service user involvement in care planning was perceived reluctance or lack of interest of the service user; this is particularly pertinent to AO teams where the reason for contact is non-engagement and where Community Treatment Orders may be in place. Other barriers identified include the process, which can be seen as irrelevant or tedious by the service user, or distressing content which from the service provider perspective can be unhelpful in sustaining a therapeutic relationship:

> *"It's quite difficult sometimes because when people certainly come to us a lot of the time they don't really want to see the paperwork and they don't really want to see the risk assessment, don't really want to see the care plan, sometimes they'll talk to us about the care plan but they don't want copies of it and they don't want to, and sometimes people don't want to talk about it or see it at all and a care plan doesn't mean anything to them in that sort of sense but I think we do try to keep trying to engage with them in that."* (TM; AOT; C)

> *"Well, no you get to read it and if you disagree with it then it gets revised. And sometimes when I've read it it's made me feel so unhappy and cross that I've had a strop about it and they've assured me that that one's been deleted and the next one will be better. Because last winter we had mice in the house and I was ... [unclear] so there was this care plan about a mice infestation, which made it sound like they were running around everywhere, but I only got to see one. No, I didn't want my care plan to consist of, sound like it was sort of pretty rank, but I think that's the nature of living near an abandoned apple orchard in a very old house. (SU; AOT; F)*

A service user's poor literacy skills were also identified as an occasional barrier to their full involvement in this area. In order to address some of the problems of service user involvement and in response to service user feedback, in one Trust, the Care Plan has been replaced by a 'Well-Being Plan', which is written in more service user-centred terms. Two participating teams also talked about the use of other devices to help identify service user goals and review progress towards these, which had been introduced recently either by the team or the Trust.

Improved service user well-being emerged as the central goal of the participating teams and, in working towards this, there is a clear emphasis on assisting service users to maximise the positive potential of their lives. The limitation on 'recovery' for some service users was highlighted, however. Service user involvement in care planning was generally presented by participants as

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standard practice, although a number of impeding factors to the effectiveness of this were identified.

4.8.2 Creative problem solving

Three broad issues were explored under this heading:
- How far the team seeks tailored/innovative solutions/treatments for service users
- How far the team explores new ways to provide care
- How far the team shares knowledge about good practice

This section describes some of the approaches to problem solving mentioned by interviewees, and identifies the enabling factors and barriers to these. Enablers included mechanisms to enable sharing of good practice, diversity of team membership, good leadership from senior team members, and utilisation of external resources. Barriers included a lack of time and other resources (although conversely these could encourage creativity also), rigidity of some processes and team members, and external constraints placed on the teams.

In general, service providers appeared to find this topic more difficult to address than others. However a number of broad areas were identified which were considered to be factors in effectively **seeking out, exploring and sharing knowledge about innovative and good practice.** The issue of resources, both internal to the team/Trust and external, was prominent, regardless of the type of team. In particular, participants suggested that a team's ability to be creative and innovative was dependent on good staff resources, affording team members freedom from 'fire-fighting'. Several interviewees (mainly from Early Intervention teams) indicated that their team was relatively rich in resources and was, therefore, able to exercise greater creativity than might be found elsewhere in community mental health services. Others pointed to team efforts to provide such 'space' by making best use of their resources through mechanisms that limit or clear case-loads or effect prompt discharge of service users when appropriate. Many mentioned seeking out appropriate external resources, principally in the not-for-profit sector:

> "[I] think it's about using the resource that is there and trying to not ghettoise … younger people's mental health problems by saying you need to come along to this special group that we're running for young people with mental health problems. It's very much about let's get you into mainstream access points of services that are just there generically in the community. We've had some pretty creative work, yes, I think with specific individuals." (CPN/Clinical TL; EI; G)

However, very many participants raised the issue of lack of internal resources, both staff time and financial, as limiting their team's ability to be creative.

> *"Well, I don't think there are any limits really I think that the only sort of limit on us is time. So there may be some patients who would really, really benefit from you say taking them for a day at the seaside, because that was what they remembered their parents doing for them when they were little and that would mean so much for them to do that. We obviously can't do that, and we are, time is probably our most valuable resource really."* (Support; AOT; G)

Lack of external resources was also identified by participants as a barrier to creativity; however, it was also suggested that lack of resources might in themselves enable creativity:

> *"I think we're trying to be more and more creative because of the almost barriers that are put upon us for what we can offer, like I say, rooms, materials, resources and people to run groups with."* (OT; AOT; C)

A second major area that participants identified as relevant to creativity, concerns the inter-relationship between the team's task, the character of the service users engaged with and the philosophy or ethos of service-provision. Some interviewees pointed out that the basic purpose of their work was to be creative, because the task they are engaged in is in some way novel:

> *"But thinking outside the box just widens it up for the service user to be able to access a lot more and the team, I think they've got a lot better at doing that … since the word 'recovery' has become more focused. People now have to think outside the box because there isn't much in mental health to attach people to do, so you have to look outside for other things for people to do and to be able to access."* (CPN; R&R; G)

A third group of issues participants identified as relevant to team creativity concerns team practices, processes and dynamics. In relation to enabling creativity, service providers pointed to a number of factors, including role flexibility, team member autonomy and making the best use of diversity in team member expertise and skills:

> *"Yes, and I think that, a lot of that comes with the team approach, because you've got a lot of professionals with different backgrounds. So you get lots of different ideas which sometimes can cause friction, if you like, because not everyone always agrees, but I think it's really good to get that sort of advice from someone else or see it from a different view … here you get a lot of different opinions which can be really helpful."* (CPN; AOT; F)

Leadership from 'senior' team members, especially team managers and consultant psychiatrists was mentioned by some participants as enabling

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creativity. Another prominent enabling factor indicated by interviewees, however, was the various opportunities team members have to examine their practice, share ideas and learn from one another, and also from sources external to the team:

> *"So we will invite people in to the meeting so that they tell us what they've got out there and as soon as we find out about something new, it's like going in and going oh would you like to come and tell us about it, if we can put you in, the Wednesday meetings are normally really for guest speakers to come in and tell us a little bit about what's going on in different areas." (CPN; EI; J)*

Several participants indicated that failure to make use of such opportunities could impede the development of a team's creative problem solving. The issue of resource constraints, particularly time, was frequently raised in this context.

Assurance of psychological safety and quality of communication were also identified by participants as being particularly pertinent to these processes:

> *"I think another part of it is it can depend very much on the individuals in the team. I think you need a team that is open to suggestions, open to, you know, maybe take risks with things to see how they go, a new way of doing something and I think the team hasn't always been brilliant at that, at saying 'OK, I might not agree with that idea, but let's give it a go.' I think the individual staff can have a great influence on that. Part of it is people feeling free to make ideas without feeling sort of flattened or, you know, might be ridiculed or whatever, an idea however off the wall it might be actually is welcomed rather than saying that's stupid idea." (CPN; AOT; C)*

A final barrier to creative problem solving identified by interviewees was the constraints placed on practice by Trust and central government objectives and administrative systems:

> *"I'm sorry am I being very negative here? But I think your creativity and working in the NHS in a team like this is limited, because you have to work according to what they want and what the job requires of you and as you know these days there's hundreds and hundreds of forms to be filled in, so I would say your creativity is limited." (Specialist Dr; SM; J)*

Generally, therefore, service user participants regarded the nature of the team task and its service user-centred orientation as primary engendering factors for team creativity. However, they also identified the many different opportunities they have for mutual learning in meetings and other forums and the personal attributes of team members as important, while team resources were seen as central.

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4.8.3 Continuous care

Three broad issues were explored under this heading:
- Whether the team achieves continuity of service user care
- How well continuity is managed within the team
- How successfully information is shared with other agencies

In this section we explore the factors that enable and hinder the provision of continuous care to service users. Enabling factors included the sharing of caseloads and team structures that ensured service users knew more than one professional, a variety of intra-team communication and professional-service user communication methods, the maintenance of good electronic records, and adequate provision of support workers. Barriers included lack of clarity in the face of restructuring, inadequate resources for the caseload, lack of clarity about team caseloads, and poor inter-team relationships and referral processes.

Overall, service users and carers were positive about their experience of their team with regard to continuous care, although there were instances where this was clearly problematic. In particular, it was clear from their accounts that communication between service users and carers and teams was generally effectively maintained. Any unexpected disruption to the care provided, or need for additional contact, was managed and resolved appropriately. Where participants could identify instances of broken continuity, they were generally unable to suggest what factors had contributed to this, beyond a service provider being unexpectedly absent from work.

A general issue that arose in service provider interviews was that a team's efforts to maintain continuity might be at the expense of other aspects of their work. Both overall quality and recording were mentioned in this context. However, failure to maintain written communication in itself was identified as an impediment to continuous care:

> *"Well, there used not to be when we had inadequate staff to have time to write recordkeeping and handovers and things. During our difficult period that I, shall I say, that was a huge problem because people didn't have time to be able to keep adequate records or spend the time handing over or whatever. It is something that is really improving now." (SW; CRHT; G)*

A further issue that emerged strongly is how models of case-load management interface with the matter of continuous care. It is evident that the different models can be seen as both enabling and impeding continuity. While all participating teams worked within the Care Plan Approach which demands the identification of a care co-ordinator, the extent to which this arrangement is nominal varied between the teams. In most, this system was sitting alongside some level of team responsibility for the maintenance of care. In the organisation of the team task, Assertive Outreach teams came closest to the notion of a 'team-caseload' by which all team members participate in decision making about the care provided and all (or most) might have involvement in delivering the

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care. In all other teams, there was at least team consultation about aspects of service users' care and sometimes team decision making, especially about risk.

How a team's model of working could be said to enable **the achievement of continuity of service user care and its management within the team** was addressed extensively by participants. Focused contact was cited by many in this context; it was considered, variously, to ensure that care is consistent (especially important in relation to dementia), that an appropriate therapeutic relationship can develop, that service users know who to contact and that care is properly coordinated.

Even where work was usually organised more on the lines of a team case-load, several participants indicated that if a service user found this difficult, in order to maintain continuity, teams might make special arrangements:

> *"We do, it is a team approach, but there are a few people that will only see either their care coordinator or they build up a better rapport with certain people. You know, it's human nature isn't it, you can't, you don't get on with everybody do you, but the majority we all see but there are one or two that will only see certain people, yeah." (Support; AOT; F)*

However, adopting a team case-load approach or, at least, ensuring service users know or have involvement with a number of or all team members was also thought to enable continuity:

> *"Over time with various crises and having to pop to see people for different reasons, a lot of the patients, especially the longstanding patients, get to meet a few of us. So if I'm away then they will have met one of the other nurses for a telephone call or whatever at some point. And as time goes on, the likelihood of that increases. (CPN; CMHT; E)*

For several interviewees, the regularity of the contact arrangements (including mediation regimes) established with service users was a central factor enabling continuity. A team's flexibility over their assessment of service users for suitability or the length of time or terms on which a service is provided was also seen by some service providers to assist in the maintenance of continuous care:

> *"And so what we've noticed happening is they will then say, this person's had this treatment but they aren't quite there, they need a few more months of CBT doing on this, that and the other, and the GP will then refer to us. So we wouldn't put them on CPA, we're just sort of I suppose finishing off what the other service aren't able to." (CPN/TC; CMHT; E)*

In addition, low staff turnover in a team and, therefore, the maintenance of relationships and the retention of knowledge about a service user over time was raised by many service-providers as an enabling factor.

The quality of intra-team communication and information-sharing about service users' care and the mechanisms through which this is accomplished was considered a central issue in enabling the continuity of care for many participants. Factors mentioned relating to verbal communication included regular team meetings to exchange information, frequent informal information-sharing, and having a small team in which disseminating information is relatively easy (this last point was also mentioned by service users). A wide range of written information, particularly care plans, was also identified as helpful.

> *"And any meeting, any referral, anything to do with that particular person is shared with the team so in theory it's quite easy for any one of us to step in and either start to work with the client or cover a visit for sickness, annual leave …" (CPN; AOT; C)*

> *"I think we're very hot on CPA, we're very hot on reviews, and I know certainly with paperwork that I see from other teams on CPA we are pretty good on those things. So I think those things prevent people and things slipping through the net." (SW; CMHT; E)*

Other enabling methods of written communication cited by interviewees included clinical notes, minutes of meetings, message books, weekly contact sheets, shared electronic diaries, the team diary, and the hand-over book containing a brief summary of last contact with a service user. Other forms of communication were also mentioned, including utilising knowledge held by carers, and using methods appropriate to the service user (e. g., texting).

Preparation for planned and unplanned team member absences was critical to maintaining continuity. Some mentioned contingency and crisis plans being included in service users' care plans, and the nomination of an associate care co-ordinator or other worker who could provide cover in case of absence; many service providers indicated that their team also operate an office duty system to provide cover.

> *"I've been told there's a standby, who I was told if I need help, he's on the same team ... and yeah, I mean I've got no problem because that's what X says, you know there's always someone, Y is her backup and if she's not there or she's ill she's got Y who I will speak to. So I'm really happy with that." (SU; R&R; J)*

Several interviewees mentioned helping service users with coping strategies in case of key worker absence, the willingness of service users to cope with alteration to arrangements and gaining the agreement of service users about who they are willing to see in the absence of their usual contact:

> *"If they're a bit busy or people are off ill I'll say, 'Do you know what, I'm just phoning in to say that I'll manage this week. I am quite down but I'll manage, because I know next week when everyone's back up on the team I'll get that*

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visit, I'll get a strong input from that person that'll bring me back up.'" (SU; AO; C)

Many service providers indicated that their team had established procedures to deal with planned absence. Some participants indicated, however, that the mechanisms in place were dependent on the capacity of team members to undertake extra work and that team resources were important in this context. The availability of support workers was mentioned as particularly enabling:

"The support workers would probably be the other source of contact. If somebody's got a support worker as well as main nurse, the support worker would probably try and do an extra appointment while the care coordinator was on holiday." (Admin; CMHT; F)

Several service provider interviewees mentioned consultation and monitoring processes - such as the availability of senior team members or managers for consultation, regular management supervision and periodic case audit – as further contributing to continuous care. The inference here was that 'another pair of eyes' might effectively pick up and draw attention to actual or potential lapses in continuity. Finally, a variety of skills and attributes possessed by team members were identified as relevant. These included the broad knowledge of individual workers obviating the need to await specialist input, having different professionals involved so that all areas of need are addressed, the willingness of team members to cover for others and their colleagues' confidence in them to do so appropriately, the willingness of team members to work outside of their contractual hours, and the responsiveness and professional approach of team members.

In looking at impediments to achieving continuity of care, some interviewees again saw the individual case-load/team case-load issue as relevant. It was suggested, for example, that input from many team members could lead to lack of goal focus, while there were problems with individual working in relation to unexpected absence and part-time working:

"You know, one problem can be a piece of work isn't always finished off or carried on, and that has happened from time-to-time. We have tried various ways of improving it and I don't think we've hit on the perfect way yet. For example we, you know, experimented with bringing the care plans to the Monday meeting, so everyone was clear OK the overall goals with these people, this is what we said we're going to be doing, so we try and stay focused on what we'd agreed with the client we're going to be doing." (CPN; AOT; C)

Lack of stability and continuity in team membership was also mentioned prominently in this context. Issues raised included the six-monthly turnover of psychiatric registrars, consultant psychiatrist posts being filled by locums, inability to appoint locums to other posts, staff being appointed on temporary contracts, loss of team members and their knowledge of service users through

restructuring and early retirement, and poor induction of new staff due to rapid turnover.

Factors relating to Trust or team inputs and processes were also identified as impediments to maintaining continuity. These included lack of clarity about task design, lack of flexibility in the team in relation to roles/skills so work is not continued when a team member is on leave or leaves, and, in particular, pressure of work through high case-loads, sometimes due to loss of staff in relation to Trust restructuring:

> *"All I would say is we just need to have more staff to actually cover so that the individual person is responsible for a smaller caseload because you get to the point where, with the complexity, if you've got too big a caseload, you can't cover everything and an ex-colleague of mine was a counsellor and once said that if you can only spin five plates, and they give you seven to spin, all seven fall down. It's not the extra two. The whole lot goes down." (Specialist Dr; SM; G)*

The issue of restructuring was also identified as being associated with loss of knowledge about systems and processes and, prominently, with low team morale and resilience. These issues again were thought to impede the maintenance of continuity.

Many service providers were confident in their team's ability successfully to **share information with other teams/agencies and achieve inter-team/agency continuity** of care; however, it was also acknowledged that this could be inconsistent:

> *"Some teams are great, other teams awful; it really is luck of the draw, unfortunately." (OT; AOT; J)*

As in relation to inter-team and inter-agency working (Section 4.8.4), participants identified numerous ways they worked with others to ensure information would be transmitted and continuity maintained. These included routine practices (such as notifying emergency teams as appropriate about vulnerable service users), joint decision making and joint-working of various sorts, and formal linking and liaison:

> *"Yeah, my client who I referred to home treatment, rather than just leaving it to home treatment, we'll organise joint reviews or I'll organise joint reviews, so I'll go and see my client along with home treatment once to twice a week and obviously liaise on the phone … There's a lot of joint working and shared care plans." (CPN; EI; J)*

Further factors identified that enable continuity with other teams relate to routine processes being in place for planned transfer of care:

> *"Obviously, they get introduced to their new case worker with their old case worker, and there's a good six months that they look to plan and make a plan to be moving on. So it's never done quickly, it's a good process, kind of*

looking to where would be best for them to go, meeting the new care worker, giving the new care worker an understanding of who they're going to be working with and what's worked in the past or hasn't worked in the past." (Admin; EI; G)

Beyond poor communication due to lack of electronic recording, the issue that service providers most frequently mentioned as impeding continuity with other teams was the change in responsible consultant psychiatrist when a service user is admitted to hospital:

"I think one of the things that has changed that I don't think is for the better, and that's the reconfiguration with the consultants being an inpatient and an outpatient consultant. I don't know if that particularly works for us and I don't know if it particularly works for the service users either. And I think continuity there is difficult, and I think we are the king pin to the continuity then really because we are the voice then for the service users between the inpatient and the outpatient services really." (SW; CMHT; E)

Also raised in this context was incapacity in other parts of a Trust to meet service user need, sometimes resulting in the team being used simply as a 'holding space' until other services became available. Issues relating to inter-team referrals were also mentioned in this context. These included lack of clarity about team referral criteria, disagreements with other teams about referral/transfer and the readiness with which other teams deal with referrals. Referral is addressed in more detail in Section 4.8.4 on inter-team working.

Finally, some interviewees raised the matter of different procedures and parameters for different services leading to service user confusion and loss of continuity:

"Clients are not stupid. They know, they get frustrated by how long it's taking for appointments or what's happening with things so I think that they do know that there's a difficulty with the interface, but also because they receive a different kind of care from CAMHS, from adults and from us. When you're a child receiving care, you know, you might be taken to the appointments and it's structured, then when you go into adult services the emphasis is on you make your own way to the appointment. If you don't make the appointments then we might reschedule it but actually if you DNA a couple of appointments then we would discharge you from our caseload and you'd have to go back to the GP for a new referral and suddenly the emphasis is on the client to be proactive rather than the service chasing them. I'm not sure that we mental health services equip our clients for making that transition from one to the other." (CPN; EI; J)

Participants did not consider maintaining continuity of care a major challenge and indicated that team task design was a primary factor in this. They were also able to point to numerous team processes centring on information-sharing that

further enable it. Lack of team stability, some internal Trust processes and the responses of some other agencies appeared to be the main inhibitors of maintaining continuous care.

4.8.4 Inter-team working

Two broad issues were explored under this heading:
- The clarity of the team's referral processes
- The effectiveness of the team's communication and collaboration with other mental health teams and other agencies

Inter-team working was identified as a critical issue in the effectiveness of individual teams in the first stage of this study; this was verified by the interviews conducted with service providers. Although this issue was explored with service user and carer participants, they were, in general, unable to comment about this aspect of team working. This section describes factors that were identified as enablers of good inter-team working (particularly clear and unambiguous referral processes, shared electronic service user records, joint meetings and less formal communication/individual relationships, shared premises, and a willingness to reciprocate and be flexible). It also describes others that were barriers to it (the converse of the enablers - lack of resources, a lack of understanding of different teams' remits, organisational and legal requirements, Trust and team restructuring and reorganisation).

The comment of one participant sums up service provider interviewees' overall assessment of their teams' relationships with other teams and agencies**:**

> *"They vary … from good to somewhat frustrating and frustrated, probably on both sides. None of them are fraught." (Consultant; EI; J)*

Frustration was a recurring theme in discussion and service providers were generally able to identify teams or agencies they see as posing a particular challenge. However, they were also able to point to many effective working relationships with other parts of their own organisation and a wide variety of statutory, not-for-profit and commercial organisations.

Referral processes were identified by some service providers as having a major bearing on inter-team working. There were indications that processing referrals can be an exercise in expectation management (that is, clarifying what the referrer hoped for from the team and correcting misconceptions about what might be on offer) and/or in reciprocity (negotiating for the referring team to 'take' service users from the team in exchange for those referred to the team):

> *"You know, we sometimes have to do some bargaining with the individual teams, you know, we need to transfer this person back to you, or you need to transfer that person to us, we can only take them if you can take these." (SW; AOT; C)*

However, a number of participants indicated there was potential for referral processes to generate poor relationships with other teams. This was due to a lack of agreement about the responsibility for providing a service, restrictive service criteria, and inflexibility on the part of other teams or inappropriate referrals from other agencies:

> *"I know that we're part of the same Trust, we're all mental health professionals and I often feel that we should work together as much as we possibly can and help each other out and be a little bit more flexible but sometimes it feels as though different teams can be very rigid in their thinking and almost obstructive." (CPN; EI; J)*

> *"Service users don't fit into boxes. Someone might come with a mild learning disability and autism and question mark depression and all this kind of stuff, do they go to the primary team, do they go to the learning disabilities team, do they come to us? … The worst thing in the world is … I can't stand it, is you start getting into, that's when you get into your separate team silos and everybody starts arguing." (SW; R&R; F)*

The friction between teams that can be generated by loose referral criteria was indicated by some participants, while the effectiveness of clear referral criteria in avoiding disputes was referred to by others:

> *"We've needed to be a lot clearer about a case we're going to take and a case we're not going to take and actually what we're tending to get now, which is really nice, is some of the referrals that we were previously getting…and would then end up having a three month argument about why they thought we should take them and we weren't prepared to take them, and are now almost referring to us and saying can you have a look at this, we think this is what's going on but we just want you to rule out psychosis." (CPN/Clinical TL; EI; G)*

However, the possibility of a potential service user not receiving a service at all, because of narrow referral criteria, was also pointed out:

> *"You end up spending so much time and effort arguing. And I don't particularly think that having a very clear indication of your team's criteria is helpful for service users because they end up not going anywhere because there's no service for them. So I think that can be a bureaucracy of exclusion really…" (SW; R&R; F)*

The issue of team and Trust resources were identified as intrinsic to the working of referral processes; limited capacity within the NHS system could be an impediment to a team's ability to operate effectively in this area:

> *"The teams in the city here have been particularly clogged up, so I think we sometimes get frustrated because we want to do joint working with*

people over a period of months and it takes months to even get a care coordinator nominated from another team before the work even starts, and that creates uncertainty and sort of anxiety sometimes for our clients. Because we talk about the process and they know it's going to happen but like nothing happens for a while." (Consultant; EI; G)

It was also suggested that referral processes could give rise to poor inter-team relationships where reorganisation within the Trust has led to confusion about the function of the team. This also occurred where reorganisation has resulted in a systemic service gap that teams are expected to fill by referrers. In both instances, referrals that teams consider inappropriate can increase.

In commenting on their team's overall **communication and collaboration with other mental health teams and other agencies**, the place of clear communication between teams and agencies was highlighted as a central factor in effective inter-team and agency working:

> *"I suppose there's communication errors I suppose you get with each team, there can be kind of conflict of people feeling that things like what I said about their calls not returned, things that we kind of, you know, really kind of focus on and try and do for the client. We sometimes find other teams don't kind of have the same standard or, you know, don't respond as well as we might do and I think because everyone feels kind of so passionately for the clients in the team and things like that, sometimes there can be sort of little bits of friction." (Support; AOT; C)*

Communication problems between teams and other agencies were ascribed to a variety of causes, including the failure of agencies to attend relevant meetings, the reluctance of another agency to share information, the restricted availability or frequent changes of other agency workers – or indeed a service user's reluctance to give consent to information sharing:

> *"It really is quite difficult sometimes to get them to attend meetings, safeguarding meetings, I mean we always invite the police, the relevant safer neighbourhoods representative, housing, it's quite rare to get all these people to attend when we need them there which is frustrating." (CPN; AOT; C)*

> *"There's certain information we can't share, there's certain information we're able to share. We work as a team, it is ...[unclear] to share information with client consent, but when it comes to the outside agent we're restricted unless we're given permission or you're probably forced by the law." (CPN; substance misuse; J)*

Trust-wide electronic systems were identified by participants as an enhancement to communication with other teams, while lack of these could impede it:

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> *"Within the Trust there's a big advantage now that we have electronic patient record that can be accessed by anybody, so I can look now to see if one of my patients [is] in hospital, what's been happening, what was discussed, what was agreed? Which is great, I don't have to ring anybody up, from my desk, you know."* (Consultant; AOT/R&R; J)

> *"But then you've got – all our recording is electronic now. Some of the people in the hospital can't access that, so they can't access the care plans. We have to get the care plans over there."* (SW; AOT; C)

A prominent factor identified by participants as enabling communication and collaboration, was the opportunity to develop relationships with members of other teams/agencies. This might be enabled in a number of ways, including the team having a physical location where other teams are accessible or, at least, encountered:

> *"Here, I think there's a luxury because we're all on the same site. We've got access to our inpatient services and acute, the crisis team, it's our lot really, and I think that it is quite easy to go and speak to colleagues in other teams…"* (CPN; R&R; F)

> *"The other thing is that it really promotes inter-team working. So the crisis team rather than us being three miles away, we'd have to ring them up, can you see this person over the weekend? They might want a bit more info, we end up driving over there. Now we just go downstairs, you know, speak to them face to face, so it's been great for building rapport, trust between our team and other teams."* (TM; AOT; C)

A variety of working practices and arrangements, such as joint meetings, joint-working and shared-care, and setting up of link workers, liaison workers and in-reach workers were also seen to facilitate connections:

> *"I think before, it might have been that we were invited just because the parent's got mental health but now they generally phone and ask for our support or advice about something and… it tends that we come together now and set up the meetings together so there's a lot more working across the board with Children's Services."* (CPN; R&R; F)

Relationships established by individual team members, either through purposeful activity or through working in a locality/field over time, were also identified as helpful. The issue of the development of trust in others' professional judgment was also raised in this context by a large number of participants.

> *"But I've worked in a lot of the teams, so it's helped me have an idea and a network of people that I can link in with or have dealings with. We meet up in different meetings and things, and you know people from when*

you've worked with them at different times, so that can be helpful as well." (CPN; CMHT; E)

The suggestion that the opportunity to build relationships over time is important to effective working with members of other teams was further endorsed by the view that a team's stability, with low member turn-over, is also relevant. Sharing a team manager with other teams was also considered to aid the formation of links between work groups.

Gaining understanding about the nature and scope of the work of other teams and agencies, and the constraints within which they work, was also identified as enabling communication and collaboration. It was suggested this could be enhanced by creating opportunities for direct exchanges of information:

> *"We tend to get people along or invite people along to our Wednesday meetings so that they can tell us what they do and meet us and find out what we do and things like that, which I think helps." (Specialist Dr; EI; J)*

Conversely, misunderstanding about a team's work was seen as an impediment:

> *"We refer to a unit quite a bit for respite or for rehab and I think that none of their team have got any community experience at all and I think that sometimes they don't appreciate what the pressures are, you know, that are going on in the community. 'Oh, why did she come in her nightie and dressing gown? Well, it's because you're in hospital and you can't go into the house to get any clothes because it's infested with rats, you know. Well why didn't you get that sorted? Well actually you can't do that because, you know …' I think that inpatient services don't necessarily appreciate what goes on in the community. I think they still think we swan around having coffee." (CPN; R&R; F)*

Inaction, lack of urgency, events not being taken seriously or lack of accountability on part of other agencies, were all mentioned by participants as challenging the maintenance of positive relationships with them. Some participants linked these problems to a lack of understanding about mental health, possibly due to lack of staff training:

> *"Housing is a problem, I mean we're aware that housing are supposed to have certain input, for instance, to a safeguarding meeting that we might call. I've never yet seen a housing officer here to a meeting, I don't know why. But that's an issue. And I think there's a lack of understanding about people with mental health problems, severe mental health problems." (SW; AOT; C)*

A further enabling factor identified by participants relates to a team's good reputation being established over time and its work being positively regarded by others, particularly its quality and appropriateness:

"I think because of our client group who are often quite complex and previously I think created a lot of anxiety in the community, and I think the fact that we're a small team and can respond quite quickly has been quite reassuring to a lot of agencies, particularly like housing agencies, housing departments who traditionally may have sort of given someone notice to quit." (TM; AOT; C)

Conversely, a team can be seen to operate inappropriately, and this can have a negative effect on its relationship with other agencies:

"Well child protection services more or less believe that we're apologists for our clients and perhaps they're right sometimes, I don't know. They think that we dramatically under-report the risks that we're encountering and, you know, I can't 100% deny that, it's possible that we do sometimes." (TM; SM; J)

Participants indicated that a willingness to negotiate and reciprocate, not only in respect of referrals (as discussed above), but also over taking clinical responsibility can facilitate inter-team working:

"We help out other teams quite a lot and we're doing that at the moment with a patient we're not care coordinating and they've got into a difficult situation with them, we're waiting for community forensic team to get involved, we're waiting for this meeting, so we've just stepped in. We try to be helpful …" (CPN; AOT; F)

The issues of assuming service or clinical responsibility and of failure of professional agreement, however, could be major sources of friction:

"There's always going to be things that hinder … Outside of that, short-term probably things like the kind of communication between inpatient services, home treatment and ourselves. Sometimes our views not being taken on board when somebody is an inpatient and they're going but they're fine, they're settled, and we're going no but you're not seeing the whole picture." (Specialist Dr; EI; J)

"GPs are difficult, GPs are massively difficult and, you know, it won't just be me that says that I suspect, I think that if you talk to frontline staff they'll complain the most about GPs, as GPs in theory hold the role of being a kind of an axe or an hub within the wheel of somebody's kind of care and they very rarely want to embody that position or actually act in that capacity." (TM; SM; J)

The transfer of clinical responsibility between consultant psychiatrists when a service user is admitted to hospital was cited by many participants as a particular source of difficulty in this area (as well as an issue in respect of continuity of care). Child protection issues were also identified by service providers and some service users (particularly from Substance Misuse teams) as a context in which tensions between agencies could arise. In addition, whether other teams and

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agencies will provide for service users' needs, or how they do, can be a source of friction:

> *"We have patients with very complex needs and when we go to look for housing we have lots of difficulties, because the housing don't want to accommodate our patients, because they have very complex needs and they say they won't be able to cope, they are high risk people and it's a fighting battle trying to find accommodation for our patient sometimes and that is a problem." (CPN; AOT; J)*

Finally, a major impediment to maintaining effective inter-team and agency communication and collaboration was considered to derive from the stresses many teams had experienced in relation to Trust reorganisations, which had resulted in reductions in staff and other resources:

> *"I think we, I think we are a good team. I'm not saying that everything's ideal or perfect; you go around to different teams and everyone seems to be stressed and got lots of work on … but I think people do kind of often blame every other team when people are stressed, it's everybody else's fault." (CPN; AOT; F)*

> *"I think there's just pressure on, you know, everybody at the moment and we're quite fortunate, because of all the cutbacks we haven't been affected, because we fall under the children and young person's directorate, but they've gone under adult, so people's posts have been frozen, they're not being recruited into, they're short staffed, the hospitals have had wards closed, so there's less psychiatric beds, so there's more demand on home treatment." (CPN; EI; J)*

Some participants also referred in this context to the difficulty in maintaining continuity of communication everyone experiences when services are reorganised.

Participants therefore saw the restrictiveness or otherwise of referral criteria as central to the effectiveness of referral processes and the issue of team and Trust resources was also highlighted as important. It was acknowledged that referrals could be a source of friction, but, in general, the development of positive relationships with other teams and agencies was thought to be enabled through building relationships, seeking mutual understanding, negotiation and reciprocation, and establishing a 'good' reputation.

4.8.5 Respect between professionals

Two broad issues were explored under this heading:
  • The professional respect evident between team members

- The extent team members are willing to learn from one another

This section identifies ways in which respect between team members, particularly those from different occupational groups, was described. It examines factors identified as enablers of (clear task focus, service-user centred care, cultures of shared decision making, acknowledgement of different skills, opportunities to learn from each other) and barriers to (mistrust, time pressure and lack of financial resources) such respect.

As indicated in section 4.4, there were wide differences in the professional make-up of the teams visited, but in most there would be psychiatrist(s), CPNs, occupational therapist(s), psychologist(s) and support workers, as well as administrator(s). How far team members (with the exception of doctors, psychologists and administrators) are seen principally as generic mental health workers is an issue that emerged during interviewing. Case co-ordination, which is a generic role, could be said to challenge the utilisation of specific professional knowledge and skills. This was not discussed in depth, but it is clear that subtly different models operated in participating teams, with nurses and support workers being the most 'generic' workers overall. This was raised as a matter of concern by some interviewees:

> *"I think sometimes the generic role can hold the team back in progression with things, because people are not fully using their attributes and their skills, you know, and I think it affects people's self-esteem as well." (Support; AOT; C)*

We also found that in some participating teams, the current trajectory is towards greater specialisation, while in others it is towards more generic roles and that, whichever might apply, this seems linked to loss of staff and/or new team management through reorganisation.

Another issue that emerged during interviewing was the dynamic that can sometimes be present in teams due to differing perspectives among team members on mental health/illness and its care. The two dichotomies most frequently referred to by participants were 'social versus medical' models and 'behaviourist versus psychotherapeutic' approaches. These were variously seen by interviewees as either presenting barriers to mutual respect or offering useful alternative insights.

In respect of professional respect between team members**,** a service user-focussed ethos was identified by participants to be of central importance:

> *"I guess people are putting their clients first so if you need to speak to them about their client then they're going to listen." (Specialist Dr; EI; J)*

However*,* a range of other enabling factors were also indicated. The different ways individuals' varying skills are utilised was referred to by many participants. These included the deliberate use of specialist skills as appropriate and necessary, the provision of frequent opportunities for members to contribute or

share specialist knowledge (in both formal and informal ways) and having care co-ordinators from a variety of professional backgrounds:

> *"Here I feel very much we work together and try and bring out the best of all the team members, use the best bits for each client, and I think that's, I very much value that." (Consultant; EI; G)*

The acknowledgement within the team that non-professional skills can also be relevant was also seen as enabling respect between team members:

> *"I suppose what you'd ask a support worker to do and what you'd ask a professionally qualified person to do are quite different. But as for their feedback on a person's condition and how they find someone, I think a support worker often has just as good an opinion, and maybe better opinion because they spend a lot more time with them, a bit like family members I suppose … And when they do come to you and say oh so and so is not quite so well, you'd be a fool to ignore that." (Registrar; EI; G)*

Various characteristics of decision making processes within the team were also identified by participants as enabling factors in relation to professional respect. These included an understood mechanism for joint-decision making; strong care co-ordination and clarity about the ultimate authority for decision making lying with the care co-ordinator (including to act autonomously). Other factors mentioned were; willingness of team members to negotiate over their roles/the approach taken; and having mechanisms for addressing differences of opinion and doing this promptly.

> *"So there's something about kind of if there's a difference finding a way that you can gently test it out and so one of the case managers who wasn't keen, I did a lot of negotiation and checking out what it was, what he worried about and he worked in quite, works in quite a person centred therapeutic style anyway so actually thinking about well what could I offer over and above what he offers and I slightly changed my therapy style for quite a few of his clients, which seemed completely clinically appropriate." (CPsy; EI; G)*

An inclusive environment was also seen by participants to promote respect between colleagues, although it might be argued that some aspects of inclusiveness are generated by mutual respect rather than vice versa. Included here was the expectation that everyone on the team should participate regardless of background or training. Teams displayed non-hierarchical attitudes and processes; positive inter-personal relationships, including trust; and an environment of psychological safety. This can lead to clear potential benefits for service user care:

> *"I think we miss our psychologist, for sure, definitely, because she had a way of getting you to talk about your feelings, and getting everybody to talk about their feelings, and I think that was really good. Because, it's sometimes on our Wednesday meeting, you can sit there and if all the things you are talking about are over your head, i.e. e. the sort of stuff*

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that only the qualified staff can make decisions on … she would turn around and say to you and 'How do you feel about that X?', and you would have to speak. But in actual fact I would say that pretty much everyone is interested in what everyone has to say." (Support; AOT; G)

"If I make a mistake, 'Oh, it's all right, you're only human, we all make mistakes'. I don't think there's any difference, you know, in any of the professions." (Admin; EI; G)

In addition, a lack of pressure on the team, so there is time to interact and consult with colleagues was raised as an enabling factor:

"I think the more under pressure we get, the more difficult it is perhaps to keep that in mind and sort of, or have those discussions as well that remind you that this is what each of us does … I think then there's say less chance of maybe some people having room to think, oh this person could do with this." (OT; CMHT; E)

In relation to impediments to professional respect between team members, in general participants identified the converse conditions to those seen as enabling, but contributions in this vein were generally fewer. Two areas did stand out as particularly important in this respect, however. Some interviewees commented strongly on the issue of exclusivity or hierarchy:

"Well, when there's kind of separate meetings, you know, and having been there I feel for them sometimes and wonder kind of how that affects the cohesiveness of the team and you do not want a split. A team's a team at the end of the day, you don't want no obvious kind of split there and I'm not saying that's sort of a massive problem or anything like that, but I suppose it's that potential again."(Support; AOT; C)

In addition, team members who did not always sign-up to collective decision making were felt to present a challenge to the maintenance of respect between colleagues:

"I think sometimes there is a weakness in that senior members of the team are out to take the decisions on their own and think, right I have to be honest with you, one person in the team will tend to take decisions on his own and almost it's like, if it suits him he'll take it to the team, but if it doesn't he just does it and he'll work impulsively. And I think that that can undermine the other people in the team who are working towards, we're all working towards the same goal, and he can, it almost feels like your work is being trampled on." (Support; AOT; G)

In relation to the extent team members are willing to learn from one another, many of the enabling factors were the same as those for professional respect. In particular they pointed to a wide variety of formal forums through which knowledge and expertise could be shared. Regular team meetings (whatever the frequency of these) where clinical and other on-going work is discussed were

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considered central to this, but periodic team days and away-days, regular formal reflective practice groups and clinical supervision groups, working groups, journal clubs, individual clinical supervision, team training (for example, in preparation for Practice Development Unit accreditation) and feed-back from service-users and carers (including complaints) were all cited in this respect. Several participants also mentioned the agreement that messages from conference attendance or training undertaken by team members should be 'cascaded' within the team, in the understanding that time invested by all the team in a member's absence needs to be compensated through a team learning experience.

> *"It happens, generally speaking, at our team mornings or team away days which we have every month, usually it is a morning and there is an opportunity for members of the team to present projects that they are currently working on, or individual case studies, so people that they have been working with, that kind of thing. There is a good news slot, so any new interventions, or projects generally, get a round of applause from the rest of the team, that kind of thing. Otherwise I am involved with a peer supervision group which meets every week and that's a small group of people who are interested in working psychologically with clients and that is proving to be a really valuable forum for just sharing the detail of the individual work that we are doing with people." (CPN; EI; G)*

A wide range of informal mechanisms that enable mutual learning were also identified. These included informal peer discussion or supervision groups, informal peer supervision or consultation (normally in informal settings, for example the open-plan office or kitchen), the team having lunch in the office together regularly. Other mechanisms included 'senior' clinical staff (in particular psychiatrists or psychologists) being based in the team-room or deliberately spending time in team room, and the team having trainees or students on placement, which could promote reflection about practice.

Again an environment in which team members feel psychologically safe was considered necessary to enable mutual learning. This was highlighted by the following contribution:

> *"So the complex case discussion has been very popular in that it's a kind of safe open environment where an individual feels able to maybe challenge the views of the medic, and it's, it's not really led by the psychologist. It used to be formally led by the psychologist and she would just keep us on track and then she left and we used to just facilitate it ourselves. And now we've had a new psychologist for about 18 months and she sort of sits in the background and just moves the discussion on if it's got a bit stuck. And the idea being is to kind of reflect on practice and help us to formulate a way of moving on with certain clients." (TL; AOT/R&R; J)*

Factors that participants thought impeded the creation of opportunities for mutual learning were again less readily identified than those enabling them. Lack

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of financial resources and time, however, was mentioned by some interviewees, especially in relation to team away-days:

> *"We used to have them quite regularly, we're not having away days at the moment because we haven't got any money." (SW; AOT; C)*

> *"It had slipped and we recognised it slipped, so we have introduced and everybody signed up to it, we had a meeting recently where we all got together, we had a couple of hours in the morning…This is as a group, and we're saying what we're wanting is everybody to regularly come to it. Because what's been happening is we start it and then a few people, well I can't make it, I've got this, I've got that." (CPN; R&R; F)*

Other impeding factors identified included the practice of team members receiving formal clinical or peer supervision outside the team (usually within their own professional group), apparent lack of interest among team members to meet, and resistance to change on the part of some team members, particularly those who had worked in the same post, team or Trust for a long time. Finally, the issue of lack of psychological safety in participating was again raised.

Inter-professional respect, therefore, was thought to exist in most teams and seen to derive initially from the centrality of team members' focus on the care of their service users. It could be further enabled by a team environment in which there were opportunities to utilise members' specialist and generic skills, where decision making processes were flexible, where there was a culture of inclusiveness and where there was a relative lack of pressure to manage the team task. Mutual learning between team members was seen to be advanced through a wide range of formal and informal opportunities for team members to 'converse'.

4.8.6 Responsiveness to carers

Two broad issues were explored under this heading:
- Whether carers are seen as important by the team
- Whether carers are offered information and/or services by the team

This section describes the attitudes shown to carers by service providers from both perspectives; it also identifies factors seen as enablers (communication systems, shared expectations, availability of appropriate professional expertise within teams, carer support groups, team leadership) and barriers (lack of mutual understanding, service user preferences, disregard of carers from some team members, lack of resources/time for liaising with carers).

All the carers interviewed were generally positive about their team's attitude towards carers and many talked about their involvement in carers' groups, or the carer's assessment that they had been involved in writing. In addition, many

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expressed gratitude for the work of the team with their service users (in some instances comparing this favourably to their past experiences within the mental health system). There were some who identified specific aspects of their service users' current care with which they were not completely happy or past incidents that had led to some disagreement with a care co-ordinator or consultant psychiatrist. Overall, however, it was clear that the carers we interviewed had found the participating teams appropriately responsive.

Most service providers indicated that they thought carers were of central importance to the work of the team; some were critical of other team members who did not share this view. This general stance tended to vary slightly depending on the nature of the service user group served by the team. As indicated earlier, carers would often have a more central role in the lives of both young people and older people, so both Early Intervention and Older Adults team members were most consistent in this regard. However, some service providers raised issues about carer involvement that indicated their relationship with carers is not always straightforward and can present challenges. It was pointed out, for example, that not all those who service users identify as a carer are interested in being involved or receiving a service, even if it was thought this may be helpful to them and/or the service user – and, indeed, some regard themselves not so much as a 'carer', but simply as a parent or spouse. By contrast, some carers are very proactive and involved with teams not only in the care of their service user, but also in contributing to the development of service-provision through feedback mechanisms. Another issue raised was the very difficult relationships that sometimes exist between carers and service users and that work with carers could entail more than simply 'involving' them:

> *"Quite often because a lot of our clients when they come to us, any relationships with their family [have been] just completely destroyed over the years … we almost have to engage them in the same way as the clients to get them to see and do things differently and it's not just about medication and an injection and see you in two weeks. So in many respects we would treat them exactly the same as we would the client themselves, we'd offer them education, we'd offer them help with benefits if it was relevant." (CPN; AOT; C)*

In addition, several service providers qualified their generally positive regard of carers by indicating that carers could be unhelpful, sometimes because of unrealistic expectations of the service provider:

> *"I mean in terms of sort of socialisation, those with a carer tend to be less socially isolated, but carers can sometimes be a hindrance as well as a help, you know, they can have unrealistic expectations of what you can provide as a service, or what you can do for people. They sometimes think you can change somebody's personality, or wave a magic wand and make everything better." (CPN; R&R; E)*

Despite the general caveats expressed by service providers about the role of carers and teams' responses to them, participants (both service providers and carers) were able to identify a number of factors that could enable work between them. First it was pointed out that opportunities to develop relationships with carers were vital and, intrinsic to that, was the establishment of effective communication:

> "So sometimes the things that they see us doing, and that might be one of the failings that we have, is we're not very good at explaining to people and carers how we're working with that individual … So I think that sometimes it's just the different places that we're coming from, it's the communication aspect isn't it? Different needs and different views on things." (CPN; R&R; F)

> "I don't think there's been a time where I've not been able to get hold of her and she'll always let me know if she's away. So it's good communication, you know, it's excellent." (Carer; EI; J)

The team having members with appropriate skills or awareness, deriving from their training or experience was also seen as a central enabling factor. Social Workers or Occupational Therapists were sometimes pointed to as being particularly important in this respect:

> "I guess a lot of the issues around carers and supporting carers again linked to the legislative framework is perhaps something that social workers bring to the team, knowledge about working with people, with caring." (SW; EI; G)

> "They know that I am an OT and that they'll use my skills. So they'll assess somebody and there will be like this person needs anxiety management, this person needs activity scheduling, you know, they have a carer who is struggling or needs support, and I do all their carers' assessments, carers' group, carers' champion and all that stuff." (OT; CRHT; G)

The establishment or provision of carer-specific services and involvement opportunities within the team context were also identified as important, and were sometimes linked to the existence in the team of the sort of skills and experience noted above:

> "No, I think carers groups, they're quite, they do exist in Adult Services, but I think we felt that the one for EI was particularly, it was good to have a separate one because I think some of our carers had had experiences of going to the adult ones and I think actually got quite disheartened because they had carers who'd kind of been caring for someone for, you know, 20, 30+ years and were quite, understandably quite sort of jaded about the system and quite hopeless really." (Consultant; EI; J)

"All carers are offered an assessment hopefully. We used to have a carers' assessor who was an outreach worker or maybe she was an assistant practitioner, I don't know, I think she had a bit of both roles but she's currently doing her social work training and she's on a 100 day placement so she's left us. So it's down to finding someone else to do that assessment now, which I guess is more problematic because there's not one identified person." (CPN; R&R; G)

Leadership from either within the team or the Trust was also mentioned as relevant to this issue, most prominently by those with leadership roles themselves:

"What I'm trying to introduce as a team leader is more scrutiny of what we're doing, hence the meeting you saw this morning. I want us all to see every care plan and say is there anything more we can add to this, is this the best it can be and what role do other people in this person's life play that we might be able to help facilitate, like the parents and sisters and neighbours and friends." (TL; AOT; G)

A further enabling factor raised was the willingness of the team to work with carers even where service users had withheld consent or approval:

"Obviously, the actual meeting, whether they're at the meeting or not, is up to the client. We respect their wishes, but I think we had a case recently actually where we've, the client had told us that they didn't want us to speak to their mum at all but she was desperately, she was actually very involved and stressed about it and we've been able to engage her … in the process and I think that will have helped with his care plan actually because I think because the previous team had been so worried about confidentiality that they hadn't spoken to her at all where we've been able to say well we can't tell you anything about his illness and his difficulties but we can tell you about schizophrenia in general, we can tell you about medication in general and we can answer, we can hear stuff from you. We can hear what you're concerned about and act on that if appropriate and it's really helped." (Registrar; AOT/R&R; J)

The issue of service user consent to sharing information, as the above contributions indicate, is central to relating to carers. Effective communication with carers about the team's requirement to respect service users' confidentiality was cited by some participants as an important enabling factor. However, the issue of confidentiality and its preservation was also identified as a principal impediment to being responsive to carers, at least in ways they might wish:

"It makes it very difficult when the service user then says I don't want you to speak to my mum anymore. It's very difficult because we do have a duty of confidentiality." (CPN; AOT; F)

As indicated previously, carers may themselves show opposition or reluctance to become involved and this was identified as another impediment to engaging with them - although respecting their wish for non-involvement could, of course, be construed as appropriate responsiveness.

A further impediment to responsiveness to carers mentioned by interviewees is a lack of team resources, leading to either individual prioritising or the inability of the team to make progress with planned activity:

> *"I feel compromised by sometimes I feel that there is an expectation that I am going to give equal weight to the carers needs than I do to the person that has been referred and I disagree and I resent that because, yes I accept and acknowledge that the carer is under an enormous burden themselves often but I think that we need to draw the line somewhere in terms of our limited resource." (CPN; EI; G)*

> *"It's almost like sometimes things can be suggested, but it takes an awful long time for it to be put into place and I think a lot of that's to do with funding, there's just not enough resources. So I don't blame the team, but I can see where they get their problems a little bit more of a fair share of it, because there's not enough back up. It's not their job to do that, their job to initiate it, but if the funding's not there to put the people in place it's a vicious circle." (Carer; EI; J)*

However, as indicated in a number of participants' contributions, non-responsiveness to carers also derives from a lack of team awareness or interest, or the adverse professional attitudes of team members, or lack of appreciation of the carer's perspective:

> *"I think with everything there are a few people who - I have to be honest, there are a few people on the team I think who are less, a bit more reluctant to involve carers, who possibly see it as a little bit kind of intrusive and they're less keen to involve, but I would think the bulk of the team would see it as just part and parcel of looking after the person who was in their care." (Consultant; EI; G)*

> *"Yeah, I mean carers' assessments for instance, some people think they're a waste of time … if you're looking at differences between professions I don't think the nursing staff see it as their job a lot of the time, or they're not interested, their focus is on the patient." (Support; R&R; G)*

A final difficulty highlighted by interviewees is lack of opportunity for team members and carers to liaise and communicate, given team members' patterns of work and carers' commitments. Team flexibility, therefore, was cited by participants as an enabling factor in responding to carers:

> *"We work very flexibly within our team, so I'm inclined to do that kind of thing, because obviously parents are at work, children are at college, school. That often requires making appointments until six in the evening*

sometimes, which I'm more than happy to do, because it's whenever's best really for them to be seen, rather than having to take the child out of school, take time out of work, and especially often people have other younger children and things like that they have to pick up from school, so that flexibility helps." (CPN; EI; G)

Generally, participating teams demonstrated a positive attitude towards carers and appeared to see carers as important because of their importance in service users' lives, and because of what they contribute to the total care of service users. There were few contrary voices among service providers, although the challenge that engaging with carers could sometimes present was articulated. The principal factors enabling carer responsiveness were identified as the team including individuals with professional training or experience that promotes such attitudes and the establishment of carer-specific services within the team; these two factors are probably inter-related. Leadership on this issue was also seen as important. The difficult issue of service user opposition was seen as particularly impeding to carer responsiveness, as was lack of team resources.

4.8.7 Therapeutic relationships with service users

Three issues were explored under this heading:
- The clarity of professional boundaries within the relationship
- The openness and honesty within the relationship
- The collaborative nature of the relationship

This section deals with these three issues in turn, describing the attitudes of interviewees towards these relationships, and identifying enablers of (clarity of team and individual tasks, multi-professional teams, use of treatment agreements or contracts, mutual understanding of service user needs) and barriers to (organisational restructuring, team resources, some customary working methods, shared caseloads, legal requirements, service user dependency) effective therapeutic relationships.

Developing and maintaining relationships between the team/individual team members and service users was seen and understood as the central process in the team task by all the service providers who participated in the interviews. This was the case regardless of the type of team.

The accounts of many service users indicated that, although the provision of medication and opportunities for meaningful activity were important aspects of their care, it was the relationship with one or several team members that principally defined for them the nature of the service they were receiving. Carers, while being able to comment on the quality of their own relationship with service-providers, were, inevitably less able to offer insights in this area.

In respect of **maintaining professional boundaries,** there was recognition from many service providers that the team task and the team's customary methods of working presented in themselves a challenge to team members:

> "I think potentially it is an area of difficulty, because just in our everyday work it is about being quite intrusive really, finding out and asking difficult questions and helping people who are seen as vulnerable and in need. So there is this licence to tread over people's private lives and of course getting into a kind of counselling relationship is very much about taking a lot of interest in somebody's life and also offering someone warmth and kindness which might be very unusual for them in their lives." (CPN; EI; G)

> "I think that is very difficult. I've said that many times. It's a grey area. We are working with a client group that's notorious for being very suspicious of healthcare workers and for that reason not engaging very well so you need to almost go the extra mile, and I always use the expression getting out of the playpen a little bit, but being very aware of your own limitations and that if you do that, not to stay out there because you can very quickly start to collude with a client which is dangerous to do. So it's a question of being friendly towards them but not being their friend and explaining that there are, unfortunately there are boundaries …" (Specialist Dr; SM; J)

Occasionally, service providers commented that their particular professional roles or ways of working meant that they could protect themselves from these challenges to some extent:

> "Maybe as a doctor I have the added advantage, I think, because there is maybe more of a barrier than other specialities. So I introduce myself as Dr H, you know … and I do try and keep a boundary there." (Consultant; EI; G)

Generally, service providers tended to see the issue of maintaining professional boundaries as an individual responsibility, developed through training and reviewed during practice through self-reflection, rather than being a team function.

> "I think it's up to us as professionals to make sure that that boundary is kept there. And it's inevitable because we work very closely with people and they share all sorts of things with us. It's inevitable that they are at times going to see us more as friends than professionals. And I think there are times when I suppose you can see that's happening a little, it's getting a little fudgy, and you kind of just have to sort of pull back gently a bit." (CPN; CMHT; E)

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However, clarity and focus about the team and individual task was alluded to by some service providers as being a factor that assists in this area, although the converse was sometimes also expressed. Some service providers identified opportunities for discussion or reflection within formal clinical or management supervision as also assisting the maintenance of boundaries. The availability of guidance or support on an informal basis from other team members was identified as a potential aid in this area.

> "I mean I'm a qualified nurse, I've got my own sort of code of conduct, I dare not sort of work outside that conduct because otherwise I'll get the sack, be totally against my professional code of conduct. So it's always on my mind, you've got to be mindful about how I conduct myself, what I do, I continually seek support and supervision to ensure that my practice is within. If I find a situation where I'm sort of not comfortable, I always take it to supervision and I check out with my seniors to guide me whether I'm doing the right thing or not." (CPN; SM; J)

Some team processes were also identified as enabling factors in this context. Joint decision making was considered by some service providers to be relevant. Processes and opportunities to manage service users' expectations were also seen as enabling. In some instances, this is through a formal 'treatment agreement' (SM teams) or a formal introduction into the team. However, some service providers indicated that their preference was for clarifying boundaries only if the need arose:

> "I think sometimes they might need to be reminded or for it to be made explicit that there is a boundary. I can think of colleagues when clients have asked them if they'd like to meet up you know later in the evening, or whether they'd like to meet up as friends … that's a clear opportunity to say you know, these are the limits of my involvement with you." (CPN; EI; G)

In relation to **openness and honesty**, service providers frequently expressed the view that this was a central tenet of their relationship with service users. Many providers were able, however, to identify some impediments to maintaining honesty and openness at all times. A service users' cognitive ability or insight about her condition was thought, for example, to sometimes hinder this. The need to develop or maintain a positive relationship or to avoid causing a service user undue distress was also cited as an instance where complete honesty might be sacrificed. Conversely, recognition was given that service users' insight and understanding can promote openness and honesty in the relationship, and that effective communication was a necessary feature of this process:

> "I think that depends very much on the client actually … I mean one particular client we've managed to keep out of hospital for 18 months whereas previously he's had very rapid admissions and a lot of that has

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> *been about the communication between us and the client and when he says I'm having a bad day, this is how I want it managed, going a little bit, trusting a little bit and taking a little bit of risk and going with him …" (SW; R&R; J)*

In addition the enabling role of treatment agreements or contracts that formalise the relationship between the team and the service user was cited in relation to the work of substance misuse teams.

In respect of **collaborative working**, service users were generally confident about the nature of their relationship with team members. Most carers also considered that service users were able to work collaboratively with providers, although this in itself could sometimes be an area of tension for carers.

In general, service providers identified collaborative working as a central ideal of their practice. However, they also identified many inhibitors to achieving collaborative working. In some instances, particularly for Assertive Outreach teams, the shared team task can be a challenge to the ideal:

> *"I mean as I said before us kind of going away or leaving people to it kind of thing isn't really an option, so given that you could view that as maybe quite restrictive, you know, potentially quite restrictive, but I mean we always try to keep people's, their beliefs, sort of their values at the core of what we're doing, but at the same time we give them the message that we aren't going to let go easily." (TM; AOT; C)*

Issues of risk in relation to the service user and the safeguarding of others - and the attendant legal considerations – were also identified as challenges to the maintenance of collaboration.

Service users' expectations of their involvement with the team or their stated wishes was also seen as a hindrance to collaborative working by some service providers; conversely, service providers also spoke about the obstacles to collaboration when service users are unable to articulate their wishes (as noted above by a carer) or defer readily to the views of the provider.

> *"You know sometimes the most very basic things that people want in life, it doesn't matter who they are, is something to do, somewhere to live and someone to love. Some of those we can't always provide." (CPN; AOT; F)*

Sometimes service providers also identified what they considered to be service user dependency as hindering collaboration, especially where this was at odds with the team task:

> *"So they're not, some of them are maybe a bit too dependent on the services, they do need a bit of encouragement and jiggling along to make them see that they can do things for themselves and they don't always need to be helped along as such. But yes, I think as a rule they don't actually push people to do it, say you have to do this, this is what life is about, but yeah I think as a rule they do have to gently try and make them see it because otherwise they would be too dependent. (Admin; R&R; F)*

On occasions, however, the barriers to collaboration can originate in a service provider's definition of a service user's needs, especially when these are not aligned closely with how the team understands its task:

> *"Well, it can be sort of relatively simple things like for example how a person lives … You know, sometimes the staff will say actually I don't want to go into that environment it's too dirty, that's fair enough, because at least you're being honest, but if you're saying actually the client needs this, but it isn't the client who's asking for it then there's a little bit of confusion whose needs, are you working in a client centred way, who's defining recovery in that sense?" (CPN; AOT; C)*

Service providers also identified conditions relating to organisational restructuring and/or financial constraints and/or the introduction of new models of working as hindering collaborative relationships with service users:

> *"[W]ith all the, I don't know all the stuff that we get flung at us from above, it's very hard to keep the person at the centre. For instance, like getting someone into residential care, the Panel, the Mental Health Funding Panel now say that you mustn't take the service user to look at the place before you apply for funding. And we say well how can they have any choice then? You know, but you have to specify what home you're looking at, but you haven't even taken the person to look at it and they say, 'Oh well, the funding is in principle'. But then how you can work with someone when you're not giving them choice, so that sort of thing you know." (SW; R&R; G)*

> *"You know, for example the philosophy and context in which you work changes from time to time, sometimes we get that from above right we're all working to recovery now and their definition of that seems to be well we're closing this service and the person has to go somewhere else for the service, well that seems to be not recovery, because you need to negotiate with each of those people first what they want, but sometimes, you know, from above they say well you don't want a drop in centre anymore, that's not recovery focused, you need to go to college. Which is fine if somebody wants to go to college, but someone who says actually I want to go to the drop in that decision's been taken away from them, it's been something imposed from above, which isn't really recovery in my opinion." (CPN; AOT; C)*

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"I think the staff that we've got are very service user led in their intervention. Less so just because of the pressure we're getting from our managers to change the way that we work slightly, well not slightly, completely, which goes against the grain for a lot of us, but generally most of the conversations that I had are around improving the experience for the service user and making sure they're central to any interventions." (CPN; R&R; F)

Aids to promoting collaboration were less readily identified by service providers. However, it was recognised by some that even in the present climate of constraint, a team's remit, and the resources available to them because of this, means that it is more able to maintain this ideal:

"[I]t's quite a holistic approach, so in terms of kind of well-being it's not just nursing and not just psychological and not just housing. It's kind of across the board and so hopefully, you know, speaking plainly it may be a bit of a sales job and because they've got more time there's a smaller caseload so they've got more time to invest in clients that are difficult to engage. They are able to be more successful I suppose." (CPsy; AOT; C)

"I think we know our patients extremely well compared to other mental health teams because we can get to know them much better. We have a lot lower case load than a CMHT would so I think we know the patients very well individually and I think that is always good if you're seeing them regularly and regularly discussing the plan with them, they're going to by the very nature of it have involvement in it." (Registrar; AOT/R&R; J)

The multi-professional composition of the team was also identified as a source of assistance in maintaining collaboration:

"Well I think that the way forward is obviously on the service user's terms, but I think that we are there to guide them, and that is the beauty of having a multidisciplinary team because everybody has different strengths and different things that they'll notice, and like we'll all discuss the cases, and so somebody might say, 'Oh have you thought of doing this or have you thought of suggesting that?', and so yeah it is on their terms, but we do, we do guide." (Support; AOT; G)

In general, therefore, the establishment and maintenance of therapeutic relationships between service providers and service users was seen by participants to be central to the work of the teams and as the central characteristic of service users' contact with teams. Within this, collaborative working between service providers and service users was depicted as not only a matter of team practice, but of team ethos. Adhering to this ideal was seen by service providers as sometimes challenged by issues of risk, different understandings of 'need' and limited resources, however. Maintaining professional boundaries within the therapeutic relationship between service

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providers and service users seems to present few difficulties. Service providers identified a number of factors, principally concerning consultation and information-sharing between team members, which enable this. Openness and honesty appears to be a more difficult aspect of the therapeutic relationship to sustain. Here the main challenges identified by service providers related primarily to the level of insight service users have about their mental health and the need to balance honesty with the overall aim of maintaining a therapeutic relationship.

4.9 Conclusions

The interviews with team members, service users and carers revealed much about factors that enabled and inhibited team effectiveness, particularly with regard to the seven themes uncovered in Stage 1.

One of the most important recurring features was available resources. This particularly featured in terms of staff availability (both in bodies available and workload), and was closely linked to the reorganisations that many teams had recently undergone, or were undergoing. This was apparent to not only service providers, but to service users and carers also.

The clarity of the team task was an issue that became evident, both in interviews and in observations of team meetings. Teams which had less clear tasks (and less clear service user populations) displayed less focus and less effectiveness. The quality of communication was also seen as important – this includes intra-team communication, but also communication with other CMHTs, other agencies, and also with service users and carers directly (for example, an electronic record system helped greatly).

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5 Discussion

5.1 Facilitators and inhibitors of effective multi-professional team working

In this chapter, we summarise, synthesise and describe the principal findings emerging from the quantitative research of Stage 2, and enriched or interpreted by findings from the qualitative research of Stage 3. We consider the findings in relation to five overarching themes that emerged:

- Team functioning and effectiveness
- Leadership
- Resources
- Organizational structure and work design
- Inter-team working

We then consider the wider applications of the measures used in this research, practical implications of the findings, the limitations of the research and recommendations for future research in this domain. The findings are broadly in line with research into team functioning generally [92] and health care teams more specifically [93, 94, 95], but the factors emerging as most important are specific in their combination to CMHTs and the detail of how these factors influence CMHT effectiveness is both important and novel.

5.1.1 Team functioning and effectiveness

Within the NHS generally, team working is developed with variable effectiveness. Recent reports suggest a high proportion of staff working in teams, but only a minority working in teams satisfying the minimal conditions for effective team working [91]. Studies using the ATPI in the NHS show that teams report being poorly resourced and have inadequate organisational support. They have generally low levels of reflexivity, only irregularly or never taking time out to review their objectives, processes and performance and adapting accordingly.

They report working relatively ineffectively with other teams and generally have low levels of innovation, evidenced by their introduction of new and improved ways of delivering patient care. More positively, NHS staff report relatively good levels of skill and sustained effort in their teams, clear objectives and task focus, and high levels of team effectiveness (see Table 5.1, comparison data based on 289 teams from across different parts of the NHS).

In comparison, the present study finds lower levels still of resources and organizational support among CMHTs. Self-reported team effectiveness is also lower amongst these teams than effectiveness among NHS teams more generally. CMHTs see themselves as relatively low in effectiveness on the ATPI measure which assesses the extent of managerial praise for effectiveness and achievement of goals rather than actual effectiveness or productivity. This suggests that managers are not giving teams high levels of praise and recognition for their performance, either because team performance is poor or because managers are neglecting this function.

In comparison with the norm sample of teams, CMHTs score rather higher in relation to levels of task focus and participation. They report a strong focus on the needs of clients, a good level of constructive debate, an emphasis on quality and a preparedness to discuss errors and mistakes constructively. Moreover, team members say there is a relatively high level of trust, safety and support, good involvement of team members in decision making, good communication and regular meetings. Team member satisfaction tends to be high and there is a strong sense of attachment to the team and its members. Levels of team innovation – the development of new services and ways of working – are high in comparison with other NHS teams.

Table 5.1
Comparison of CMHTs with other NHS teams

	CMHT sample – Mean (SD)	289 NHS teams - Mean (SD)
Task design	3.61 (0.27)	3.60 (0.28)
Team effort and skills	3.68 (0.36)	3.69 (0.42)
Organisational support	3.28 (0.32)	3.42 (0.39)
Resources	2.66 (0.46)	2.88 (0.57)
Objectives	3.78 (0.38)	3.77 (0.40)
Reflexivity	3.44 (0.35)	3.38 (0.46)
Participation	3.82 (0.40)	3.62 (0.48)
Task focus	3.83 (0.29)	3.71 (0.36)
Team conflict	2.36 (0.41)	2.36 (0.48)
Creativity and innovation	3.65 (0.39)	3.62 (0.46)
Leadership 1	3.67 (0.45)	3.66 (0.47)
Leadership 2	3.79 (0.45)	3.70 (0.47)
Leadership 3	3.87 (0.46)	3.81 (0.49)
Team member satisfaction	3.75 (0.34)	3.65 (0.43)
Attachment	4.01 (0.37)	3.94 (0.46)
Team effectiveness	2.95 (0.49)	3.14 (0.52)

| Inter-team relationships | 3.03 (0.35) | 3.18 (0.42) |
| Team Innovation | 3.50 (0.39) | 3.44 (0.47) |

Examination of scores by different team types within the sample shows that Early Intervention teams score highest in relation to task design – interdependence, clear feedback, relevance, autonomy and doing a complete task. They also score highest in relation to team effort and skills – the level of motivation of team members, the appropriateness of skills available in the team to do the task and the degree to which team members believe the team can be successful. In contrast Generic CMHTs and Rehabilitation and Recovery teams have the lowest scores on these dimensions.

Older Adults CMHTs report the highest levels of organizational supports (information and communication, training for team working and climate for team working) and resources available to them, closely followed by Early Intervention teams. Lowest levels of these inputs are reported by Generic CMHTs and Substance Misuse teams but with only three of the latter team types in the sample, these results are unreliable. The data suggest the need to provide more support generally to Generic CMHTs.

These patterns are also reflected in how team members see their teams in action. Early Intervention team members see themselves as having clear, agreed objectives, with high levels of participation, low levels of team conflict and real support for new and improved services. Generic CMHTs, in contrast, have relatively low scores on all these dimensions. These patterns are repeated in team assessments of the quality of their leadership (Early Interventions teams reporting the best leadership and Generic CMHTs the worst) and outcomes. Early Intervention teams score highest on team attachment, team member satisfaction, team effectiveness and team innovation. Only in relation to inter-team relationships were they slightly less effective than Older Adults CMHTs. Lowest scores were consistently reported by Generic CMHTs – significantly lower than both Early Intervention teams and Older Adult CMHTs.

Broadly, the more positive climates were found in those team types that were fulfilling a specialist task: i.e. Early Intervention teams, Assertive Outreach teams, and to a lesser extent Crisis Resolution/Home Treatment teams. In contrast, those teams without such a specific brief, referred to as generic CMHTs in this report, had poorer processes, reflecting less conducive and less optimistic team climates. This manifested itself in poorer clarity of team objectives and task focus, less opportunity for reflection, lower levels of participation in decision making, more intra-team conflict and less creativity within teams.

Informants commented that EI teams tend to have a clearer remit than other teams. They often agree with clients that they will work with them for a specified time period on particular issues. Because they tend to work with younger people at the beginning of their mental health problems, they also see successes more than other teams. The EI teams tend to be truly multidisciplinary. Clients work

with a number of staff, so there is joint working which means that staff understand the skills of different professionals. Often there are regular meetings where all clients are reviewed, so that shared learning occurs in the process of identifying good and poor practices.

In contrast, Substance Misuse teams are often housed in run-down areas of the city and in poor accommodation. The majority of staff are support workers, with other qualified staff having limited input. Clients are seen by one worker and so there is little joint working or learning. Their clients usually have complex needs and remain in the service for a long time. This can lead to a lack of hope or belief that change is possible.

Generic CMHTs are a mixture of these two ways of working. There is joint working, but the focus of the work at a team level lacks clarity. Clients may remain in the service for a long time and are likely to have complex needs.

It is not surprising then that there was considerable variation in clarity of team objectives by team type, and this appeared to contribute to the differential effectiveness of teams. For example, interviewees told us objectives were more easily defined in Crisis Resolution/Home Treatment teams who were focused on preventing service users' admission to hospital; in Assertive Outreach teams concerned with stabilisation of medication and maximisation of functioning; and in Early Intervention teams who focus on intense intervention to address psychosis and assist social recovery. They were less well defined in other team types. The fact that these more focused teams consistently outperformed other types of teams in the quantitative study suggests that clarity of goals is a key factor in enabling effective team functioning. This is consistent with previous research on health care team functioning and with knowledge about effective teamwork more generally [92, 94].

Respondents reported that a strong, shared focus on service users facilitated greater respect between professionals, as did valuing of non-professional skills and sharing of specialist knowledge. Good inter-personal relationships, trust and psychological safety also contributed to respect between professionals and this in turn influenced effective service user care. Having a mix of professional backgrounds amongst care co-ordinators also helped. Good channels of communication between team members were found to enable better continuous care for service users. Such communication included effective meetings, but subsumed also informal communication and good written communication e.g., detailed care plans, electronic access , meeting minutes, contact sheets, team diaries, and hand-over documentation.

Team creativity (measured by the items 'People in the team are quick to offer help to try out new ways of doing things'; 'In this team we seek out and support ideas for new products / services'; and 'We support each other's ideas for new and improved ways of doing the team's work') was the single strongest predictor of effectiveness in the survey followed by participation in decision making. These findings were reflected in interviews and in observation of team

meetings, where it was clear that more informed decisions and proposals for new and improved ways of providing care were made in meetings where team members were able to contribute to the process. This required the psychological safety for all staff (including junior staff) to make contributions and feel that their views would be respected. It also required well-structured meetings that allowed time for discussion when the need occurred. It was important that individual team members felt able to challenge the status quo. Teams were more likely to be creative when they reflected on their practice, team members learned from each other, and all members were involved in discussions. This occurred particularly when there was a feeling of psychological safety to participate and make suggestions, members offered practical support and there were resources available to implement innovative ideas.

Based on our findings and experience, we suggest the CMHT works best as a provider of supportive relationships to service users if it functions successfully as an emotionally resilient group in its own right. One could draw an analogy with family or friendship groups as providers of emotional support in the non-work world, and the need for them to be functional themselves for them to function as effective sources of emotional support. This is further emphasised by conflict being an important predictor of effectiveness and also of inter-team relationships – low levels of conflict were associated with better outcomes. In many of the meetings we observed, there were good examples of inter-personal positivity, humour and optimism which created a feeling of psychological safety, enabling people to participate fully in discussions and decisions. Interviews also revealed the value of clear decision making procedures which ensured understanding of joint decision making mechanisms, but also gave clarity about where final authority and responsibility lay.

Similarly, reflexivity appeared to play an important role. Especially for generic CMHTs, where team objectives were not clear , having the space and time to reflect on these was beneficial to team performance. Thus there were high levels of reflexivity in the meetings of the more successful teams. During the main meetings this was often limited to short reflections about clinical decisions made. However, some had occasional meetings or away-days to learn from each other about new practices, to augment their training and to improve work processes.

5.1.2 Leadership

Each of the leadership process scales was significantly correlated with both of the measures of impact on staff (for team member satisfaction, $r = .76$; for attachment, $r = .62$). This is consistent with evidence from other studies, using a wide range of leadership tools, that leadership behaviour is significantly positively correlated with measures of staff satisfaction, job and organizational commitment, motivation and intention to stay [51, 100-102]. Each of the leadership process scales was also significantly correlated with each of the three self-reported output measures, (team effectiveness, $r = .67$; inter-team relationships, $r = .51$; and team innovation, $r = .55$). Team effectiveness was

assessed with reference to managerial praise and goal achievement; inter-team relationships with reference to co-operation with other teams and absence of destructive conflict with other teams; and team innovation with reference to development of new products, services, and ways of working. CMHT effectiveness, assessed by team members using dimensions proposed by them along with mental health service users and carers, was significantly correlated with each of the leadership process scales ($r = .64$). These findings among mental health teams are consistent with evidence from teams in private and other public sector organizations that leadership plays a crucial role in team effectiveness [53].

There were high inter-correlations between the three leadership scales of the ATPI ($r = .93$ – see Table 3.8), suggesting some redundancy but there was also evidence of differential relationships between the three scales and the outputs (team member satisfaction, attachment, team effectiveness, inter-team relations, team innovation, CMHT effectiveness) and evidence of differences by type of team. The data presented in Table 3.20 show that team members are most satisfied and committed to the team when the team leader is available to discuss problems, shows concern to meet the needs and aspirations of team members, encourages and supports team members, and provides a supportive learning environment (Leadership 3). These same behaviours, in combination with setting direction, acquiring appropriate resources, and supporting innovation (Leadership 1), predict positive inter-team relationships. Both Leadership 3 behaviours and Leadership 2 behaviours (giving guidance, monitoring, giving helpful feedback, and encouraging inter-team working) predict team innovation.

Where there was sufficient data to undertake meaningful analyses between types of team, Early Intervention Teams rated their leadership processes more highly than any other team (Table 3.11). Among the generic CMHTs, the Leadership 2 scale (giving guidance, monitoring, giving helpful feedback, and encouraging inter-team working) was the best predictor of team effectiveness (Table 3.17). Leadership 2 was one of three significant predictors of effectiveness in these teams. The others were participation and creativity. This suggests that a combination of team support for creativity and innovation and team member participation in decision making along with these leadership behaviours is most effective in promoting team effectiveness (judged using the CMHT effectiveness measure). This is consistent with Zaccaro and Klimoski's emphasis [96, 97] on the importance of the team processes/leadership interface. In summary, all three leadership scales predict team effectiveness. Leaders of mental health teams are likely to be most effective when they help to set direction, acquire needed resources, support innovation, give guidance, monitor team and team member progress, give helpful feedback, encourage inter-team working, are available to discuss problems, show concern to meet the needs and aspirations of team members, encourage and support their team members, and provide a supportive learning environment.

Turning to the case study data on leadership, *the clarity of leadership* within teams was revealed by the interviews to be particularly important . A lack of

clear leadership in the face of change, in particular about implementing decisions and making changes to service provision, was potentially damaging.

A most important leadership role, whether or not it was undertaken by the formal team leader was *chairing the team meeting*. This is the main forum for team members to meet, and as well as being a critical part of the service user care process, enabled the tone to be set for the team in terms of climate, culture and affect. A competently run meeting, with clear focus on the tasks to be completed, combined with an air of positivity and space to discuss and reflect was beneficial to service user care. Encouraging information sharing, facilitating discussions, exploring opposing opinions, and making decisions were all critical roles performed by the meeting chair that enabled efficient and effective team performance.

Leadership was critical for *supporting team innovation*. The innovative process requires sufficient psychological safety for individuals to challenge the status quo and to generate suggestions for alternatives. Dominant personalities, particularly if negative or pessimistic, were a barrier to this process. Innovation was also sometimes stifled by externally imposed structures or models of working. For example, some targets and monitoring procedures were seen by team members as antithetical or irrelevant to high quality service user care. It is the role of the team leader to determine where flexibility within the system lies and to challenge authority if appropriate. Whereas some imposed targets may be rigid, others may be negotiated at local level.

One of the main barriers to innovation, as well as to other aspects of effective performance, was having a poor mix of skills and attributes within the team. This related not just to professions and numbers of staff, but also to *positive attitudes towards change* and working practices. The ability of a team leader to inculcate willingness to change, coach team members in new working methods, and manage the process effectively determined the extent to which the creativity of team members translated to better team performance. Team leaders are not automatically able to lead a team owing to their clinical expertise and experience. They require appropriate support and training to enable effective leadership.

The role of *carer involvement* within the care process varied significantly between teams. Although most service providers interviewed indicated that they thought carers were of central importance to the work of the team, some said not all colleagues shared this view. Some of the carers interviewed recalled experiences where they had not been involved when they had wanted to be. There was general consensus within the first stage of the research that appropriate involvement of carers was desirable, and many examples were given about how carers had been left frustrated by the inability to contribute to care decisions, either because of lack of interest from team members or lack of agreement from the service users themselves. Thus one specific aspect with which team leaders can assist is by setting the expectation for how carers are involved in the process and ensuring appropriate resources and procedures are in place for this. This may involve, for example, developing specific protocols for

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carer involvement, and/or the setting up of carer groups to enable appropriate sharing of information and support.

What emerged from these case study data in relation to team leadership is consistent with what emerged from corresponding data among high performing CRHTs, both in relation to the culture of such teams, and the lessons to be learned [30].

5.1.3 Resources

It was clear from the qualitative data that resources were seen as an important factor by all teams, albeit that some teams were better resourced than others.

One of the most important resources available to a team, and the cause of much concern, was the professional time available to deal with cases. Work pressure, which was cited by most participants as a critical factor, was seen as a barrier to all aspects of team effectiveness, including intra- and inter-team relationships, and creative problem solving. This finding is consistent with a recent review of job satisfaction and burnout in CMHTs [107].

Resources also included space to think, freedom from continual fire-fighting, and availability of external resources, including voluntary services and networks. Team composition is also an important resource, because creativity stems from individual attributes such as perseverance, lateral thinking, confidence, extra-role behaviours and optimism. All these resources enabled creativity and innovation, which emerged from the research as the single strongest predictor of CMHT effectiveness.

External demands can also affect team processes. According to some respondents, a lack of resources can force creativity. This echoes recent research by Schippers et al. [100], which showed that when primary health care teams faced high demands, either in terms of caseload or physical working environment, they became more innovative, provided they were also reflexive (i.e., taking the time to reflect upon their processes and performance, and adapt accordingly). High team demands can therefore stimulate the team and generate benefits such as more innovation and reflection). However, there are likely to be thresholds in the demands-innovation relationship. El Ansari and Phillips [101] found that relationships between the costs and benefits of health service partnerships are 'biphasic'. In the first phase, at manageable levels of difficulty, as costs such as involvement increased, benefits such as satisfaction also increased. Eventually, a 'tipping point' of less tolerable levels of difficulties was reached and a further increase in involvement was associated with fewer benefits .

The availability of specialist knowledge within teams is important; many teams cited the lack of a dedicated clinical psychologist, and the availability of psychiatrists to teams was often stretched. Even when funding was available for

such posts, absenteeism and turnover could cause bottlenecks leading to poorer delivery of care. Used well, the multi-professional composition of teams enabled good relationships with service users, because of the varied strengths colleagues could contribute. Senior clinicians being based physically with other team members facilitated better service for users and helped to engender respect between professionals. The intricate interlacing of multi-disciplinary contributions to generate an effective outcome is a vital factor to which team members and team leaders should be attentive [111].

Time to develop professionally was seen as important but was not always available. In high performing teams team leaders supported team members in developing their strengths and worked to create a learning culture.

An overarching theme in the interviews was the importance of team leadership in accessing the resources needed, whilst minimising the barriers to enable effective delivery of care [112].

5.1.4 Organisational structure and work design

The quantitative research produced strong evidence of better team functioning and outputs amongst *teams that have a clearer remits* - the Early Intervention, Assertive Outreach and Crisis Resolution/Home Treatment teams. Individual interviews with service providers confirmed the importance of clarity of purpose in achieving good outcomes. They suggested that these more focused teams had identified time to reflect, internalised the need to innovate, had a shared interest in service users' needs and manifested lateral thinking and willingness to work outside of contracts. Perceived time pressures, inflexibility, externally imposed ways of working and bureaucracy were seen as key hindrances more typical of generic CMHTs. Various factors in focused teams were identified as influencing continuous care, respect between professionals and therapeutic relationships with service users. These included clarity of purpose, mutual respect, flexibility, professionalism, and stability and maturity of inter-team relationships.

The teams which had greater clarity of purpose were those that were established following the 2001 initiatives. Early Intervention, Assertive Outreach and Crisis Intervention/Home Treatment teams were all developed in response to emerging research findings and were supported, in most cases, by new funding. They were introduced to provide for identified groups of clients and to fulfil specified sets of tasks in relation to those groups. Their predecessors, generic mental health teams, had been Jacks and Jills of all trades, visiting the "chronic psychotic" to administer depot medication each month, providing cognitive behaviour therapy for the anxious and depressed, and fire-fighting with the acutely distressed and disturbed. In their time these teams had been innovators. Early stages of de-incarceration from large institutions in the 1960s and 1970s did not include such provision and it was only as it became evidently necessary during the later decades of the 20th century that generic CMHTs were established. The 2001

innovations were a further development of this, as the requirements of providing for the "mentally ill" in community settings became clearer. Thus we find greater clarity of purpose and observable benefits of team working amongst these more clearly defined teams, and problems amongst teams that are not so clearly defined. Older adults mental health services have grown as a specialty over the same period of time and Older Adults teams have acquired a distinct identity which is reflected in their relatively good performance on the measures we have used.

Another factor in one of these team types in particular, Assertive Outreach (AO) teams, was the *sharing of caseloads*. Most AO teams participating in the qualitative study operated some level of shared caseload. This generally meant that, although one key worker might be officially allocated to a service user, efforts were made to ensure service users got to know a number of team members. Smaller teams proved more effective in achieving this. However, involvement of too many professionals sometimes caused confusion, especially for service users. Conversely, care provided by isolated individuals also led to problems, as did unilateral decision making by care co-ordinators. Turnover of staff is obviously unhelpful for continuity of care also. The production of contingency plans seemed to be helpful here, such as the appointment of associate care co-ordinators to take over in the event of absence, and helping service users develop coping strategies in the case of staff absence .

Another potential challenge with shared caseloads was the development of successful therapeutic relationships between service providers and service users. The importance of openness and honesty, combined with the need for professional boundaries was is helped by longer term relationships between individual team members and service users. There was some feeling among service users that seeing multiple service providers could be frustrating. It appeared that the ideal situation was when individual relationships between providers and service users could be built up, but with some involvement of other team members also [113].

A clear finding was the importance of team processes that enabled creativity and participation in the delivery of service user care. Earlier we referred to an analogy between the community mental health team and informal sources of emotional support such as family or friendship groups, and the extent to which the success of both are dependent upon their collective emotional well-being and resilience. Amongst CMHTs this was reflected in teams having close but bounded, and professional but individualised relationships with their clients. This emotionally demanding work depends upon a team atmosphere of trust and mutual respect and on opportunities for creative flexibility, all factors the research has identified as important determinants of outcome. Those developing new care pathways must therefore ensure *change is managed effectively* in a way that facilitates rather than undermines stable and trusting relationships between team members. The research suggested that change or loss of team focus can cause conflicts between professionals and that reorganisation can

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cause responsibilities for anything other than case work to be neglected. Several service providers commented that restructuring of services, or the imposition of new models of working, sometimes led to poorer therapeutic relationships with service users and poorer relationships between team members.

Two important issues emerge from this research as guides to those who might commission and organise the provision of mental health services. Those at the front line need a clear remit, and if they are going to succeed they also need to work in a multi-professional context of trust and mutual respect. These are not easy conditions to provide. Mental health difficulties are emotionally challenging and amongst the least well-understood problems public services are faced with. Commissioning services which have a clear remit but which do not oversimplify, is a difficult balance. This research suggests that an historical perspective might be helpful. Within little more than half a century provision for the majority of those with mental health difficulties has moved from asylum care to community care. In the course of that transition, generic mental health teams have played their part but this work demonstrates that teams charged with providing for one set of difficulties (early psychosis, poor engagement, acute difficulties or the needs of old age) are able to fulfil their remit more successfully than generic teams. Of course there are limits to the value of sub-dividing the task of providing community mental health services, not least of which is the parallel need for creative variability, diversity and participation amongst team members. But our findings suggest that one organisational challenge is to *commission teams to provide for particular sub-sets of the needy* so that they can base what they do upon a clearly defined set of objectives.

This research emphasises the direct effect of team creativity and innovation upon important outcomes and thus draws commissioners' and managers' attention to the importance of these matters. *Targets, bureaucracy, staff shortages, high levels of turnover and inflexible ways of working* are not just unfortunate inconveniences. They have a direct effect upon outcomes, stifling creativity and participation. They also impact upon team members' ability to develop and maintain supportive and trusting relationships with one another, which are so central to the team's effectiveness as a source of emotional support to clients. An analogy might be drawn from medical history. Until the mid-nineteenth century keeping wounds and operating theatres clean was considered desirable but not essential. When it was understood that microorganisms were responsible for wound infections and their effects could be mitigated by the use of sterile technique a paradigm shift occurred. As a result of much closer attention to cleanliness and sterility, mortality from leg amputation fell from around 60% in 1860 to around 10% in 1910. Healthy, happy teams could be considered the asepsis of mental health services, and therefore of much higher priority than simply keeping the workforce satisfied. Commissioners and service managers must consider how their decisions affect teams' abilities to form into and function as emotionally healthy and resilient groupings, as this is an essential prerequisite of their task.

Regular team meetings for case discussion were seen as very helpful by most interviewees. This tallies with the survey finding that participation in decision making was one of the most important predictors of effectiveness. Other formal communication methods seen as useful were periodic reflection meetings (including away days or half days), and formal reflective practice groups, clinical supervision groups, and team supervision. Mechanisms to elicit feedback from service users and carers were also viewed as helpful to service user care.

5.1.5 Inter-team working

Inter-team working in MPTW includes cooperation with other teams within the same organisation such as other mental health teams that might be responsible for a service user's previous or future care, teams in other agencies such as housing associations, police, other parts of the NHS, or non-formal teams/individuals such as carers. A recurring theme in this research was the importance of inter-team working. In line with theory and research on organizational intergroup relations [39, 40, 116, 117], both the quality of relationships and the clarity of procedures between teams, in particular during transition periods, were identified in Stage 1 workshops as critical to MPTW effectiveness. The quantitative survey data similarly suggested that high quality intergroup relations were associated with effective teamwork ($r = .46$).

The frequency and quality of cooperative contact between teams [42, 116, 117] was the most significant characteristic of high quality intergroup relationships: Effective inter-team working was enabled by physical proximity, frequent contact between members of different teams, and joint meetings. Sometimes managers were shared, which in many instances facilitated cross-team cooperation. Establishing cooperative relationships between teams however required considerable effort, including structural initiatives to enable contact, and individual efforts by team members to maintain good relationships. Thus, managers and practitioners should be conscious about the importance of both informal and formal measures to improve relationships among teams. Examples of such measures include freeing up time for coordination with members of other teams in the form of visits, exchanges and gatherings, as well as formally scheduling inter-team meetings, either through team 'boundary spanners' (individuals charged with ensuring cross team collaboration) or representatives [9], or with teams as a whole. During transition periods where demands were high and time was scarce, such activities benefited MPTW effectiveness through reducing misunderstandings, improving communication and facilitating coordination.

The qualitative research highlighted the importance of *clear and smooth inter-team communications* to deliver care for service users. Imperfections in this area were a common source of dissatisfaction amongst practitioners. Where present such problems usually emanated from a tendency in some teams to draw rigid boundaries around their tasks and responsibilities. Although this provides helpful

focus and is attractive to those seeking to commodify mental health services, it is a disservice to service users. When needs cannot be met by one team, or one set of skills or practitioners, then smooth and ready involvement of others should follow. Unfortunately, the research has shown that, all too often such circumstances were met with disputes over referral criteria, protocols of transfer and delay. The organisational challenge is to enable optimal team working by nurturing atmospheres of creativity and participation around particular sets of tasks while recognising that individual service users' needs can be complex and multifaceted demanding effective inter-team collaboration.

Electronic availability of care plans helped significantly here, as did clear processes for transfer of care. Moreover, testing out the suitability of a new service before discharge was important. Often communication between teams was seen as poor, with a lack of shared access to records, and poor attendance at joint meetings. Sometimes there was a perceived reluctance to share relevant information. Non-alignment of approaches between teams also caused significant communication problems.

In the MPTW context, *ensuring effective referral processes* was key for effective inter-team working. In order to provide and maintain an effective service, clarity about whose responsibility it is to provide which service, and precisely where professional responsibility lies, was paramount. Too often this was not the case, resulting in a lack of efficient or effective care, and inappropriate referrals from other agencies, with obvious knock-on effects. This was exacerbated by perceptions of inflexibility amongst teams.

Thus, leaders of multi-professional teams should agree upon and *integrate inter-team goals and objectives* into their work, incorporating them into their team objectives [9], in order to avoid disagreements over responsibilities with other teams. 'Silo mentalities' of individual teams aiming to work relatively independently from other health care providers might be mitigated by setting up a more integrative organisational reward structure [39]. Rewarding teams exclusively for accomplishments constrained to their functional orientation can lead teams to excel at the expense of other teams, and ultimately service users. Instead, managers might *recognise and reward inter-team cooperation* within and across organizational boundaries [40, 41].

Because inter-team cooperation is organized around service user needs, *service users can exacerbate problems of inter-team working*. Sometimes challenging behaviour from service users created problems between teams, especially where one team was not specialist in mental health issues (e.g. housing agencies). Moreover, whereas liaison with carers is important for high quality service user care, service users' reluctance to share necessary information with the carer sometimes aggravated effective collaboration between teams. Thus difficult service users can put considerable strain on inter-team working, but may in turn benefit from well-orchestrated, high quality inter-team relationships. The importance of effective inter-team relations for MPTW effectiveness is most

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pronounced where service user conditions are complicated and require the concerted efforts of more than one team.

In conclusion, this research suggests that practitioners and leaders should promote good inter-team relationships by using inter-team rewards; including inter-team goals among their team's objectives; rotating team members; sharing managers among teams; scheduling joint meetings and frequent, regular, informal communication between members of different teams. At senior level, managers can create a climate of cooperation through *highlighting cross-team cooperation*, as well as introducing measures that *foster employees' identification with the organization as a whole* [9].

5.2 Measuring multi-professional team working processes and effectiveness

5.2.1 The Aston Team Performance Inventory

Use of the ATPI [53] as a measurement tool offered an informative picture of the functioning of Community Mental Health Teams in England. Applied across 135 teams in 11 different localities (covering six of the nine government regions), the data collected provides a clear and reliable picture of CMHT inputs, processes and outputs, aided by the comparison with teams in other parts of the NHS. Use of the ATPI alongside the new CMHT effectiveness measure proved particularly powerful. It provided additional validity data for each measure, but also identified dimensions of the ATPI that were closely associated with team effectiveness in CMHTs such as creativity and innovation. The leadership scales were also strongly correlated with team effectiveness.

This study provided a large benchmark comparison group and set of norm data that makes the ATPI's use attractive as an improvement tool for CMHTs wishing to determine their strengths and weaknesses. It would be useful to apply the ATPI to a variety of multi-professional teams, provide feedback based on the data and evaluate the extent to which this leads to team development and effectiveness. Enhanced by guidance about how to strengthen those aspects of team functioning, identified as weak in the survey outcomes, the ATPI could prove powerful across health and social care settings [53, 92]. Structured research examining the efficacy of the ATPI as a basis for interventions to improve team working would be particularly useful.

5.2.2 The CMHT Effectiveness Scale

Another contribution of this research was the development of a new tool for the measurement of effectiveness in Community Mental Health Teams. Although a similar tool exists [118], the new scale has two significant advantages. First, it was developed in the era of specialist teams, and therefore is appropriate for the range of team types now typical of mental health services. This makes it a particularly powerful tool for NHS Trusts, as it would be applicable across the whole range of teams providing mental health services to adults in the community. In certain team types (Assertive Outreach, Early Intervention, Rehabilitation and Recovery, and Older Adults) we collected enough data to provide a benchmark group.

Second, the involvement of service users and carers in the development process ensured that the dimensions reflected factors that these groups considered most important . Three of the seven dimensions were service user well-being, therapeutic relationships with service users, and responsiveness to carers. These areas were not well covered in the pre-existing measure . Moreover the scale has resonance with service providers and service users and carers as indicated by the

positive reaction of study participants to the completed scale. The appropriateness of the inclusion of service users and carers in the development process depends of course on the subject, but it is a means of ensuring better face and contextual validity.

Another significant benefit of the research was demonstrating the applicability of the method of scale development. Using a large number of stakeholders in three phases, we were able to identify key dimensions of effectiveness, then to describe what these dimensions should constitute, and finally to refine and weight questionnaire items. This process proved valuable and could be applied to other settings within the NHS.

In summary, a psychometrically robust scale of mental health team effectiveness will be of value to commissioners and service providers and will offer a valuable source of information about the functioning of mental health teams that will guide decision makers in the future. *We therefore recommend its use both as a team self report measure and as a scale for use by stakeholders of teams, including senior managers.*

5.3 Practical implications and recommendations

The commissioning, resourcing, design and maintenance of mental health teams is about to enter uncharted territory as we enter a period of more devolved local commissioning. There is a need for clear guidance to inform local commissioning and service improvement about the structure and functioning of mental health teams. Our recommendations are intended to offer such guidance. The recommendations have not been separated out by stakeholder group as their achievement is the responsibility of a range of local participants. Nor have they been separated out by team type except insofar as some teams may require a slightly different emphasis. How teams operate in practice is subject to so many intra-team and contextual characteristics that strictly delineating recommendations as applying to specific team types is unlikely to be valid. And since many of the key variables here are highly correlated, what is likely to be useful for one kind of team is likely to be useful for another.

We offer five broad sets of recommendations and elaborate on each below. None of these recommendations is entirely novel in the broader domain of team research but the details as they apply to CMHTs certainly are. The recommendations in priority order are:

1. Clarify the purpose and function of CMHTs

2. Provide high quality leadership

3. Actively manage team composition and processes

4. Promote inter-team working

5. Ensure reflection and adaptation

6. Hold effective team meetings

1. Clarifying the purpose and function of CMHTs

Early Intervention teams and Assertive Outreach teams benefited from clarity over their client group that was lacking in other team configurations. *Clear specification of purpose and team objectives* provides a cornerstone for good team design based on approaches where the quality of care provided for service users is sovereign. This is a feature both of personalisation and effective service design [126]. Such clarity also helps to foster effective participation partly through increased practitioner role clarity and reduced conflict about purpose and processes as a consequence. When team members are clear about their team's objectives, they can shape and develop clear roles and ways of working interdependently and effectively. This is a major challenge for senior managers in the NHS. If generic CMHTs are to be maintained, then teams will need greater clarity about their purpose and objectives in order that they can reap the benefits of working in team contexts where team purpose is clear rather than diffuse.

The effective Early Intervention teams tended to have good leadership, perhaps reflecting their clear purpose and objectives. The managerial aspects of leadership such as guiding the team towards effective performance, giving effective feedback, and recognising good performance were particularly important in these teams. This aspect of leadership also subsumed promoting inter-team working. Generic CMHTs were likely to have more complex managerial arrangements, for example including social care staff or joint accountability arrangements. In this context effective organisational support to reduce conflict and promote reflective participation is particularly important. Where local needs assessment reveals a continued need for a more generic service, particular attention will need to be given to clarifying team objectives, the effective provision of information, good communication, and specific training for team working. This is important in the wake of the NSF years where generic CMHTs often feel they are the most neglected and under-specified aspect of community team provision.

The converse may be true for Older Adult teams who appear to have both clarity of purpose and good organisational support. The fact that they have such good organisational support and resources may reflect shifts in recent central government policy away from general adult mental health (emphasised in the National Service Framework for Mental Health over a decade ago) to a focus on older adults and particularly those requiring dementia services.

There is a sense of adult mental health having had its day in the sun which risks this area being experienced as a Cinderella service. Given what we now know about the costs of poor mental health among populations [113], it is crucial that local commissioners and managers ensure that mental health services are visibly afforded the clarity of purpose, value and priority they require.

2. Provide high quality leadership

The results and previous research highlight the importance of the organisational context for the team and the role the leader plays in creating this context for team members to be able to work to their best [112]. The research showed how team leadership can create effective, innovative teams, good inter-team working, high team member satisfaction and attachment, and effective intra team processes, such as creativity and low or constructive conflict.

The leadership behaviours highlighted could usefully form the basis for team reflective practice, and the coaching of people with responsibility for designing, leading and managing teams. On the basis of this study, such interventions would usefully stress developing effective team leadership in three dimensions:

Purpose, goals and objectives
- Continually clarifying vision, purpose and team objectives
- Helping team members clarify their individual roles and objectives

Organizational context
- Clarifying the features of leadership required in this context and ensuring that accountability and responsibility are clear [122]
- Understanding the demands of leading within complex systems including the importance of distributed leadership, devolved decision making and self organisation within clear parameters and as informed by purpose from the end user perspective [123, 124]
- Negotiating and influencing for an appropriate level and type of resources
- Understanding service design and service improvement science that is driven by purpose as perceived by service users [127]
- Leading inter-team cooperation and championing effective inter-team working
- Actively managing the external environment, including the demands of performance management regimes
- Managing change effectively
- Promoting effective team processes
- Using an engaging leadership style that shows genuine commitment to meeting the needs and aspirations of team members
- Maintaining a supportive learning environment
- Creating and maintaining effective systems for communication, recording and reporting beyond the team meeting, including the use of electronic systems.
- Time management to ensure that the team leader is available to discuss problems and models effective self-management
- Promoting team innovation in order to continuously improve services for users

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- Providing effective feedback for the team as a whole and for individual team members
- Using strength based approaches that are encouraging and affirming [123, 125, 126]. This includes making conscious the damaging effects of cynicism and negativity (whilst retaining the value of qualified scepticism within teams and constructive controversy to avoid groupthink).
- Ensuring time and space for reflexivity in the form of away days, reflection space at the end of meetings and structured time to plan innovation
- Managing meetings, including ensuring effective decision making and team member participation and involvement
- Managing conflict effectively, including the use of mechanisms for conflict resolution at different levels (intra-team, inter-team, inter-agency)
- Ensuring ongoing processes for the effective involvement of users and their supports (carers, family friends) based on recognised positive practice
- Modelling and advocating positive attitudes to diversity within teams including professional, age, gender, culture, ethnic and other forms of diversity to ensure teams gain the creative synergies of diversity.

One key implication of these findings is the central importance of honest, trusting and respectful relationships at all levels: between users and staff, between team members, between members and their managers, and between team members from different teams. This requires that all stakeholders are alert to mutual strengths and assets. *Leaders at all levels are responsible for creating affirming, collaborative working that builds from strengths and a genuine interpersonal regard.*

3. Actively manage team composition and processes

The importance of task design and team effort and skill in this study highlights the importance of managers, leaders and commissioners promoting contexts where:

- *Team members' knowledge, skills, experience and as importantly - values and attitudes fit well with the demands of the team task.* Specifically, continuity of care is likely to be promoted through ensuring appropriate levels of social work input to the team. Another SDO study [120] has highlighted this issue stressing the need for more effective workforce planning according to current and future need, rather than historical factors. Ensuring adequate medical cover is likely to promote more effective therapeutic relationships among team members, possibly because key decision making capacity (e.g., with respect to risk management and admissions) is rooted and accessible within the team.

- *Building trust and safety* requires contexts where contributions are explicitly valued and affirmed, particularly by those in leadership roles within the teams. The use of specific techniques, such as the Solution Focused Reflective Team approach,[9] can help to achieve in depth peer consultation and support, bolstered by explicit affirmation concerning what is already working well. A positive affective tone for meetings can be promoted through a range of simple techniques, including for example simply asking what is better since the last meeting or time when the individual service user was reviewed. Such processes mirror appropriate conduct with users themselves, such as "recovery based" approaches [18, 130] that model hope, acceptance and working from strengths and assets rather than a simple and often de-energising problem focus.
- Team processes should also be designed to ensure that practitioners receive *constructive and applicable feedback*, both through shared team processes such as clinical review meetings, and through processes of peer support, supervision and appraisal. Such processes, particularly where consciously affirming, engaging and authentically concerned with team members' personal well being, skill development and aspirations enhance employee motivation and engagement [99, 131].
- Practitioners must be able to exercise *appropriate levels of autonomy*. This requires role clarity and clarity as to decision authority. For example, the team needs to clarify norms and expectations concerning decisions that can be made within the practitioner-user relationship (e. g., how and where to meet/communicate) and those that require a team decision making process.
- *Effective approaches to managing diversity*. Diversity within teams is likely to be an asset where there is a norm of positive attitudes to the value of diversity for team innovation and effectiveness.
- *Explicit and progressive mechanisms that are available to resolve conflict* often prevent conflict and ensure that where it arises it is dealt with as locally as possible, promoting capacity for further conflict resolution in future [132].
- The whole process is informed by an understanding of how natural systems operate. Teams and their relationships to other teams are an example of such systems. This includes recognising the importance of allowing self organisation within clear parameters (not over specifying

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[9] http://www.solutionsology.co.uk/trainingpages/SFRT.htm

means), and not attempting to control the inherently uncontrollable while encouraging experimentation. It also involves recognising that a change in one part of the system will impact on events in other parts. Prioritising communication and removing constraints to communication.

- Of most importance is the sovereign role of purpose as defined by end users of the system, ensuring mechanisms are in place to ensure that information on outcomes and experience of end users continuously informs improvement.

4. Promote Inter-Team Working

As with intra-team process achieving the right organisational support is key to achieving effective inter-team working. This includes having structures and processes in place that reduce inter-team conflict, as well as protocols for transfer to other teams and mechanisms for conflict resolution at local level. Clark [135] highlighted the problem of users being "bounced" around the system, with teams devoting too much energy to managing their boundaries and exclusion criteria rather than getting on and working with other teams to provide the best possible service. She advocated more mature inter-team relationships and commissioners actively monitoring bouncing. Some Trusts have implemented regular meetings of team managers to promote such improved inter-team working. This includes training effective boundary spanners (individuals from each team with responsibility for ensuring cooperative and effective working with other teams), promoting strong, positive identification with the wider aims of the organisation. Effective leadership at all levels to ensure such processes are in place is crucial, as is the broader aim of promoting effective interpersonal relationships between members of different teams. Other factors that promote effective inter-team working include frequent inter-team contact, physical proximity, joint meetings, and in some cases joint management arrangements.

5. Ensure reflection and adaptation

Teams require opportunities for reflection in order to develop their skills, improve their processes and continuously improve their productivity and the quality of care they provide. This means they should have sufficient autonomy to innovate within safe boundaries. In creating such a context, those concerned with managing and designing teams should help the team create and maintain space for reflection on team objectives and processes. This requires more than rhetorical support. It requires an expectation that such time will be defended and that this is factored into considerations of team capacity to meet local demand. Our findings underline that such time is not a luxury but rather a key component of continued effectiveness. Intelligent commissioners concerned with achieving the best outcomes for their population will want to ensure that it forms part of

service specifications. The fact that team creativity was the single strongest predictor of effective teams highlights the importance of the team context and in particular the practical support, space for reflection and learning, and the team climate, for creativity and innovation.

6. Hold effective team meetings

Team meetings should all have a clear agenda to guide the journey of the meeting, thereby ensuring shared understanding and focus. *We recommend that all mental health teams ensure their meetings are structured around a clear written agenda.* In particular, we would recommend the following:

- Arrange meetings with a clear agenda and only include items on the agenda that are important to team objectives. The choice of items for the agenda is critical: ideally these would be just the six or seven team objectives. The sovereign purpose of service for users should be the central theme of most meetings. The fewer items on the agenda, the more in-depth and productive the meeting will be. Work out rough timings for topics beforehand, to give a sense of what needs to be covered in what time frames in order to get through the agenda. Stick to the agenda unless absolutely necessary.
- Specify the start time and end time of the meeting in advance. Establish a norm of team members arriving on time. Hold the meeting in a location that is comfortable, has appropriate equipment.
- Ensure there is someone skilled to chair or coordinate the meeting. Rotating chairs is democratic but team meetings should be chaired by those who have been effectively trained to chair them.
- Encourage everyone who may have a view to share their views. Exploring ideas is helpful in decision making and meetings are usually more productive and quicker than if discussion is suppressed. Ask for the input of members who have expertise on the topic early rather than late to help shape the discussion. Use a variety of ways of encouraging discussion (have people discuss in pairs and small groups and report back). Summarise frequently. Ensure leaders or others do not dominate.
- Once views have been expressed and opinions discussed, move efficiently towards a decision. Do not defer decisions unless it is necessary (for example when crucial information is not available). Avoid passing decisions on to other meetings or committees unless this makes sense in terms of knowledge, skills and positions of the people involved. Avoid setting up sub-groups for more meetings. Avoid altogether or use voting only as a last resort.
- Keep control of the meeting and maintain a positive climate by being optimistic, warm, polite, enthusiastic and committed to the work of the meeting. Acknowledge and thank people for their contributions. Take time out if things become heated.
- Review the usefulness of the meeting at the end and how it could be improved.

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5.4 Limitations

As with most studies, there were a number of limitations with the design and accomplishment of the research. Perhaps the most significant is the lack of objective team performance data. If there were valid, objective measures of performance that could be applied across all types of team in the study then they would have been used. However, no such measures exist. For example, measures such as acute and unplanned admissions or loss of contact with users would have very different interpretations and levels within CMHTs, early intervention teams and substance misuse teams. This is partly because of the different tasks being performed by different types of team, but also because of the difficulty of defining "performance" or "effectiveness" for mental health services (as evidenced by seven separate dimensions arising from the first stage of the study). Even for a single dimension, such as improved service user well-being, no consensus exists about an adequate measure. This is a challenge for researchers to respond to. The fact that our derived measure included seven dimensions, but that these dimensions fell psychometrically into a single indicator, suggests that our measure did a good job of capturing an "overall" effectiveness dimension, but objective measures would still have been preferable.

Within the Stage 2 questionnaire study, all of the data collected were self-reported by team members. This leads to potential issues around common method bias and social desirability responding and it was noticeable that the correlations between dimensions were indeed very large. The use of relative importance analysis goes some way to mitigating this. However, it is still difficult to obtain a true understanding of, say, the extent to which inputs and processes are linked to team effectiveness. The cross-sectional design does not help this either; questions can be raised about the direction of causality between variables. Despite the clear evidence provided by the Inputs-Process-Output model, it is still possible that teams which are effective have (say) less conflict as a result. Moreover, there is likely to be some bias in responses, occasioned by team members seeking to present a positive image (social desirability bias). However, our ability to compare scores with those of other teams in the NHS, does provide a basis for comparison, revealing where CMHTs score relatively high and low.

The mixed response rate for Stage 2 could also be a concern. Although the overall response rate at 67.2% was good for a staff survey (particularly one with such a disparate, community-based sample), in some teams this was as low as 15%. All teams met the inclusion criteria for mean scores provided by Dawson's [80] selection ratio, i.e., that the observed mean score should correlate at least 0.9 with the actual team score. However, this would be a particular issue with compositions other than mean scores such as diversity indices. It is therefore

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noteworthy that one such index (age diversity) did provide relatively consistent and significant results across different outcomes.

It would have been ideal to be able to conduct more analysis within each team type. The design did not allow this, with a maximum of 32 teams for any one particular type. This meant that differential effects between inputs, processes and outputs between types of team could not be studied.

There were also a number of limitations with the Stage 3 qualitative study. The most important was the changing setting of the teams: restructuring of services meant that the team visited was often somewhat different from that included in the questionnaire survey. In one case the team was entirely different. Partly because of this restructuring, the 19 teams included were not all the best or worst in terms of effectiveness from Stage 2, as originally planned. Thus it was not possible to analyse the Stage 3 data by separating responses into two groups of high and low effectiveness, but the teams studied did represent a good range of teams on this variable.

A final concern relates to the representativeness of the sample. It could be that the teams we studied were drawn from trusts that were better at developing well structured teams and so were more willing to participate in the research. Moreover, those responding to the questionnaires might have represented a biased sample, giving us a more positive or negative picture than is actually the case nationally. To check this, we compared the average level of well structured team working in 2009 for trusts in the current study with national data on team working in mental health trusts, using data from the NHS national staff survey. The data showed that 40.7% of staff from trusts participating in the current study reported working in well-structured teams (with clear objectives, interdependent working and regularly taking time to review performance). This did not differ materially from the figure of 41.7% of staff in mental health trusts nationally, reportedly working in well structured teams ($p = 0.67$). Thus, this evidence suggests the participating trusts were not significantly better or worse in terms of team working. We also compared those trusts that participated in Stage 3 of the research with those that were not selected to see if there were differences in the extent of well structured team working. The figures were almost identical with participating trusts in Stage 3 having a rate of 40.8% of well structured team working, compared with 40.6% for those not participating in the final stage.

5.5 Future Research Directions

The findings presented in this report suggest a number of possible avenues for future research. One of the most urgent may be to examine the effect of service restructuring on service user care. There were several suggestions during the qualitative stage that there were negative impacts of this restructuring upon care quality. At a time when budgets are still being squeezed and the Health and

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Social Care Bill (2011) is beginning to have an impact, it is crucial that NHS Trusts anticipate the likely effects of changes.

Future studies might focus on particular types of team, and may therefore be able to use objective data. Even if objective outcome data are not available, other sources of data may be, for example external ratings of team effectiveness or innovation, or observation of team behaviours [119]. This would enable effects to be estimated without reliance on data that would be biased by coming from a single source. Related to this is the need for researchers to develop more reliable measures of performance such as adherence to protocols or, ideally, service user outcomes which provide an insight into the effectiveness of service user care.

One area of research that we had hoped to include in this study but was not possible due to restructuring and governance procedures was a fine-grained study observing and comparing high and low performing teams. This could add significant new understandings to extend those found in our research.

Another important area for future work is developing and evaluating interventions for CMHTs[11]. Potential interventions could range from extended programmes designed to train effective team working, to a simple feedback report (such as that provided to all teams participating in this project). Knowing what methods are most likely to lead to improvements in service user care is essential for policy makers and managers, and the systematic evaluation of such interventions would be an important step towards this [94].

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[11] This study originally included an additional stage to evaluate the effectiveness of existing interventions; however, due to the research governance difficulties described earlier this was squeezed from the project (with the consent of NIHR SDO) to ensure there was sufficient time for the first three stages

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References

1.   Jackson, S. E. Consequences of diversity in multi-disciplinary work teams. Handbook of work group psychology (Ed M A West). 1995:53-75.

2.   Zakarian, A. & Kusian, A. Forming teams: An analytical approach. IEE Transactions. 1999;31:85-97.

3.   Salas, E., Rosen, M. A. & King, H. B. Integrating teamwork into the DNA of graduate medical education: Principles for simulation-based training. Journal of Graduate Medical Education. 2009; 1, 243-244.

4.   Van der Vegt, G. S. & Bunderson, J. S. Learning and performance in multidisciplinary teams: the importance of collective team identification. Academy of Management Journal. 2005; 48:532-47.

5.   Bantel, K. A. & Jackson, S. E. Top management and innovations in banking: Does the composition of the top team make a difference? Strategic Management Journal. 1989; 10:107-24.

6.   Hambrick, D., Cho, T. & Chen, M. J. The influence of top management team heterogeneity on firms' competitive moves. Administrative Science Quarterly. 1996; 41:659-84.

7.   Murray, A. I. Top management team heterogeneity and firm performance. Strategic Management Journal. 1989; 10:125-41.

8.   Simons, T., Pelled, L. H. & Smith, K. A. Making use of difference: Diversity, debate, and decision comprehensiveness in top management teams. Academy of Management Journal. 1999; 42:662-73.

9.   Richter, A. W., West, M. A., van Dick, R. & Dawson, J. F. Boundary spanners' identification, intergroup contact and effective intergroup relations. Academy of Management Journal. 2006; 49:1252-69.

10.   Healthcare Commission (2006). National findings from the 2005 NHS Staff Survey: Key findings summary. London: Healthcare Commission.

11.   Dawson, J. F. Diverse meanings and measurements of diversity: An extension of Harrison and Klein's (2007) typology. Academy of Management; Philadelphia, USA 2007.

12. NHS Institute. The hospital mental health teams. 2006. http://www.institute.nhs.uk/index.php?option=com_mtree&task=viewlink&link_id=3818&Itemid=4932 [Accessed 11 October 2011]

13.   Department Of Health. National service framework for mental health: modern standards and service models. Department of Health. 1999.

14.   The Sainsbury Centre for Mental Health & National Institute for Mental Health in England. Transforming Mental Health Care. London: The Sainsbury Centre for Mental Health. 2004. Accessed at www.centreformentalhealth.org.uk/pdfs/Transforming_Mental_Health_Care.pdf 3rd August 2011.

15.   Shiers, D. & Smith, J. Early Intervention in Psychosis. National Mental Health Development Unit. 2010.

16.   Weaver, T., Madden, P., Charles, V., Stimson, G., Renton, A., Tyrer, P., Barnes, T., Bench, C., Middleton, H., Wright, N., Paterson, S., Shanahan, W., Seivewright, N. & Ford, C., on behalf of the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) study team. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. British Journal of Psychiatry. 2003; 183:304-313.

17.   Holloway, F. The Forgotten Need for Rehabilitation in Contemporary Mental Health Services: A position statement from the Executive Committee of the Faculty of Rehabilitation and Social Psychiatry, Royal College of Psychiatrists. London: Royal College of Psychiatrists. 2005.

18.   Shepherd, G., Boardman, J. & Slade, M. Making Recovery a Reality. London: Sainsbury Centre for Mental Health. 2008.

19.   Anthony, W. A. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal. 1993; 16:11-23.

20.   El Ansari, W. & Phillips, C. J. Empowering Health Care Workers in Africa: Partnerships in Health - Beyond the Rhetoric Towards a Model. Critical Public Health. 2001; 11(231-252).

21.   El Ansari, W. Educational Partnerships for Health: Do Stakeholders Perceive Similar Outcomes? Journal of Public Health Management and Practice. 2003; 9:136-56.

22.   West, M. A., Borrill, C. S., Dawson, J. F., Brodbeck, F., Shapiro, D. A. & Haward, R. Leadership clarity and team innovation in health care. The Leadership Quarterly. 2003;14:393-410.

23.   Borrill, C., West M. A., Shapiro, D. & Rees, A. Team working and effectiveness in health care. British Journal of Health Care. 2000; 6(364-371).

24.   Onyett, S., Linde, K., Glover, G., Floyd, S., Bradley, S. & Middleton, H. C. The Implementation of Crisis Resolution Teams in England: Findings of a National Survey 2005 - 06. Psychiatric Bulletin. 2008; 32:374-7.

25.   Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S. & King, M. The REACT study: Randomised evaluation of assertive community treatment in north London. British Medical Journal. 2006; 332:815-8.

26.   Priebe, S., Fakhoury, W., White, I., Watts, J., Bebbington, P., Billings, J., Burns, T., Johnson, S., Muijen, M., Ryrie, I. & Wright, C. Characteristics of teams, staff and patients: Associations with outcomes of patients in assertive outreach. British Journal of Psychiatry. 2004; 185:306-11.

27.   Wright, C., Catty, J., Watt, H. & Burns, T. A systematic review of home treatment services. Classification and sustainability. Social Psychiatry and Psychiatric Epidemiology. 2004; 39:789-96.

28.   Carpenter, J., Schneider, J., Brandon, T. & Wooff, D. Working in Multidisciplinary Mental Health Teams: The Impact on Social Workers and Health Professionals of Integrated Mental Health Care. British Journal of Social Work. 2003; 33(1081-1103).

29.   Lester, H. & Glasby, J. Mental health: policy and practice. Basingstoke, Palgrave-Macmillan. 2007.

30.   Alimo-Metcalfe, B., Alban-Metcalfe, J., Bradley, M., Mariathasan, J. & Samele, C. The impact of leadership factors in implementing change in complex health and social care environments: NHS Plan clinical priority for mental health crisis resolution teams. Research Paper. 2007; Project Ref: SDO/22/2002.

31.   Alimo-Metcalfe, B. & Bradley, M. (2011). Leadership for tough times: Evidence of a cause-effect relationship between engaging leadership and team productivity; a longitudinal study. (Submitted for publication).

32.   Alimo-Metcalfe, B. & Alban-Metcalfe, J. (2005). Leadership: Time for a new direction? Leadership, 1, 51-71.

33.   Bolden, R. & Gosling, J. (2006). Leadership competencies: Time to change the tune? Leadership, 2, 147-163.

34.   Hollenbeck G. P., McCall, M. W., Jr. & Silzer, R. F. Leadership competency models. Leadership Quarterly. 2006; 17:398-413.

35.   Kogler Hill, S. E. Team leadership. Leadership: Theory and practice (Ed. P. G. Northouse). 2010:241-70.

36.   West, M. A. Effective teamwork: Practical lessons from organizational research. (2nd Edition). Oxford: Blackwell Publishing 2004.

37.   Dickinson, H., Peck, E. & Davidson, D. Opportunity seized or missed? A case study of leadership and organisational change in the creation of a Care Trust. Journal of Interprofessional Care. 2007; 21:503-13.

38.   Van Knippenberg, D., Haslam, S. A. & Platow, M. J. Unity Through Diversity: Value-in-Diversity Beliefs, Work Group Diversity and Group Identification. Group Dynamics: Theory, Research and Practice. 2007; 11:207-22.

39.   Mohrmann, S. A., Cohen, S. G. & Mohrmann, A. M. Designing Team-Based Organizations: New Forms for Knowledge Work. San Francisco: Jossey-Bass. 1995.

40.   Hogg, M. A. & Terry, D. J. Social identity and self- categorization processes in organizational contexts. Academy of Management Review. 2000;25:121-40.

41.   Richter, A.W., West, M. A., Sacramento, C. A. & Hirst, G. The relationship between intergroup competition and longitudinal change in group effectiveness. Poster presented at the Annual Meeting of the Academy of Management, Honolulu, HA. 2005.

42.   Allport, G. W. The nature of prejudice. Reading, MA: Addison-Wesley. 1954.

43.   West, M. A. Reflexivity, revolution and innovation in work teams. Product development teams (Ed M M Beyerlein, D AJohnson & S T Beyerlein). 2000:1-29.

Project 08/1819/215

44.   West, M. A. & Markiewicz, L. (2004). Building team-based working: A practical guide to organizational transformation.   Oxford : Blackwell Publishing Inc.

45.   Glasby, J., Dickinson, H. & Peck, E. (eds.) Partnership working in health and social care. Special edition of Health and Social Care in the Community. 14. 2006(373-374).

46.   H. M. Government. No health without mental health: a cross-government mental health outcomes strategy for people of all ages. 2011.

47.   Glasby, J. Understanding health and social care. Bristol: Policy Press 2007.

48.   Fay, D., Borrill, C. S., Amir, Z., Haward, R. & West, M. A. Getting the most out of multidisciplinary teams: A multi-sample study of team innovation in health care. Journal of Occupational and Organizational Psychology. 2006;79:553-67.

49.   Griffin, M. A., Patterson, M. & West, M. A. Job satisfaction and team work: the role of supervisory support. Journal of Organizational Behavior. 2001;22:537-50.

50.   Haward, R. A., Borill, C. Dawson, J. F. Scully, J. Sainisbury, R. & West, M. A. Breast cancer teams: the impact of constitution, new cancer workload and methods of operation on their effectiveness. British Journal of Cancer. 2003;89(1):15-22.

51.   Borrill, C. S., West, M. A. & Jackson, J. F. The relationship between leadership, people management, staff satisfaction and intention to leave. Birmingham: Aston Business School. 2005.

52.   West, M. A., Markiewicz, L. & Shipton, H. HRM for team-based working. The human resources revolution Why putting people first matters (Ed Burke, RJ & Cooper, CL). 2006:173-9.

53.   West, M. A., Markiewicz, L. & Dawson, J. F. Aston team performance inventory: Management Set. London: ASE. 2005.

54.   Pritchard, R. D. Measuring and Improving Organizational Productivity: A Practical Guide. New York: Praeger. 1990.

55.   Pritchard, R. D., Holling, H., Lammers, F. & Clark, B. D., Eds. Improving organizational performance with the Productivity Measurement and Enhancement

Project 08/1819/215

System: An international collaboration. Huntington, New York, Nova Science 2002:1-45.

56.   Pritchard, R.D, Harrell, M.M., DiazGranados, D., & Guzman, M.J. (2008). The Productivity Measurement and Enhancement System: A Meta-Analysis. Journal of Applied Psychology, 93(3), 540-567.

57.   Braun, V., & Clarke, V. (2006) Using Thematic Analysis in Psychology. Qualitative research in psychology, 3(2), 77-101.

58.   Hinkin, T.R. (1995). A review of scale development in the study of behaviour in organizations. Journal of Management, 21, 967-988.

59.   DeVellis, R. F. (2003). Scale development: Theory and applications (2nd ed.). Thousand Oaks, CA: Sage.

60.   Hinz, A., Michalski, D., Schwarz, R. & Herzberg, P. Y. The acquiescence effect in responding to a questionnaire. GMS Psycho-Social-Medicine. 2007;4:1-9.

61.   Ilgen, D. R., Hollenbeck, J. R., Johnson, M. & Jundt, D. Teams in Organizations: From Input-Process-Output models to IMOI models. Annual Review of Psychology. 2005;57:517-43.

62.   Lance, C. E., Butts, M. M. & Michels, L. C. The sources of four commonly reported cutoff criteria: What did they really say? Organizational Research Methods. 2006;9:202-20.

63.   DeVellis RF. Scale Development: Theory and Applications Thousand Oaks, CA: Sage. 2003;2nd Edition.

64.   Conway, J. M. & Huffcutt, A. I. A review and evaluation of exploratory factor analysis practices in organizational research. Organizational Research Methods. 2003;6(147-168).

65.   Hu, L. & Bentler, P. M. Fit indices in covariance structure modeling: Sensitivity to underparameterization model misspecification. Psychological Methods. 1998;3:424-53.

66.   Bartko, J. J. On various intraclass correlation reliability coefficients. Psychological Bulletin. 1976;83(762-765).

Project 08/1819/215

67.   Klein, K., Bliese, P. D., Kozlowski, S. W. J., Dansereau, F., Gavin, M. B., Griffin, M. A., Hofmann, D. A., James, L. R., Yammarino, F. J. & Bligh, M. C. Multilevel analytical techniques: Commonalities, differences, and continuing questions. In K. J. Klein & S. W. J. Kozlowski (eds.), Multilevel theory, research, and methods in organizations: Foundations, extensions, and new directions, pages 2002;512-553.

68.   James, L. R., Demaree, R. G. & Wolf, G. An assessment of within-group interrater agreement. Journal of Applied Psychology. 1993;78:306-9.

69.   Chan, D. Functional relations among constructs in the same content domain at different levels of analysis: A typology of composition models. Journal of Applied Psychology. 1998;83(234-246).

70.   Hackman, J. R. Leading Teams: Setting the Stage for Great Performances. Harvard, USA: Harvard Business School Press. 2002.

71.   Wageman, R., Nunes, D. A. , Burruss, J. A. & Hackman, J. R. Senior leadership teams: What it takes to make them great. Boston: Harvard Business School Press. 2008.

72.   Dawson, J. F. & West, M. A. Positive and negative effects of team working in healthcare: Real and pseudo-teams and their impact on safety. Aston Business School Working Papers. 2007.

73.   Cohen, J., Cohen, P., West, S. G. & Aiken, L. S. Applied multiple regression/correlation analysis for the behavioural sciences (3rd ed.). Mahwah, NJ: Erlbaum. 2003.

74.   Johnson, J. & LeBreton, J. M. History and use of relative importance indices in organizational research. Organizational Research Methods. 2004;7, 238-257.

75.   Efron, B. & Tibshirani, R. J. An introduction to the bootstrap. London: Chapman & Hall. 1993.

76.   Muthén, L. K. & Muthén, B. O. Mplus user's guide (3rd ed.). Los Angeles: Muthén & Muthén. 1998.

77.   Blau, P. M. Inequality and heterogeneity. New York: Free Press. 1977.

78.   Blair, J. & Lacy, M. G. Statistics of ordinal variation. Sociological Methods and Research. 2000;28:251-80.

Project 08/1819/215

79.   Harrison, D. A. & Klein, K. J.. What's the difference? Diversity constructs as separation, variety, or disparity in organizations. Academy of Management Review. 2007;32, 1199-1228.

80.   Dawson, J. F. Do we have enough? The accuracy of incomplete data from small groups. Academy of Management; Seattle, USA 2003.

81.   UK Government Office Regions. 1998.

82.   Burgess, R. G. In the field: An introduction to field research. London: Unwin Hyman. 1984.

83.   Burgess, R. G. Conversation with a purpose: The ethnographic interview in education research. Studies in qualitative methodology: conducting qualitative research. 1988.

84.   Krauss, S. E., Hamzah, A., Nor, Z. M., Omar, Z., Suandi, T., Ismail, I. A., et al. Preliminary investigation and interview guide development for studying how Malaysian farmers' form their mental models of farming. The Qualitative Report. 2009;14:245-60.

85.   Glaser, B. G. & Strauss, A. L. The discovery of grounded theory: Strategies for qualitative research. New York: Aldine De Gruyter. 1967.

86.   Strauss, A. & Corbin, J. Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park CA: Sage Publications Inc. 1990.

87.   McCann, T. V. & Clark, E. Grounded theory in nursing research: Part 1-Methodology. Nurse Researcher. 2003;11:7-18.

88.   Bryman, A. Social Research Methods. Oxford: Oxford University Press. 2008.

89.   Tesch, R. Qualitative Research. Analysis Types and Software. London: Falmer Press. 1990.

90.   Creswell, J. W. Research design: Qualitative and Quantitative approaches. Thousand Oaks: Sage. 1994.

91.   West, M. A. & Dawson, J. F. NHS Staff Management and Health Service Quality. (Report to the Department of Health.). 2011.

Project 08/1819/215

92. West, M. A. (2012).: Effective teamwork: Practical lessons from organizational research. (3nd edition). Oxford: Blackwell Publishing.

93. Bosch, M., Faber, M. J., Cruijsberg, J., Voerman, G. E., Leatherman, S., Grol, R., Hulscher, M., & Wensing, M. (2009). Effectiveness of patient care teams and the role of clinical expertise and coordination: A literature review Medical Care Research Review, 66, 6 suppl: pp. 5S-35S.91.

94. West, M.A., & Lyubovnikova, J. (in press). Teamwork in Health Services for High Quality Patient Care. In E. Salas, S. Tannenbaum, D. Cohen, & G. Latham (Eds.) Developing and Enhancing High-Performance Teams: Evidence-based practices and advice. SIOP Professional Practice. Washington:APA

95. Xyrichis, A. & Lowton, K. (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. International Journal of Nursing Studies, 45, 140-153.

96. Zaccaro, S. J. & Klimoski, R. The interface of leadership and team processes. Group & Organization Management. 2002;27:4-13.

97. Day, D., Gronn, P. & Salas, E. Leadership capacity in teams. Leadership Quarterly. 2004;15, 857-880.

98. Burke, C. S., Stagl, K. C., Klein, C., Goodwin, G. F., Salas, E. & Halpin, S. M. What types of leadership behaviors are functional in teams? Leadership Quarterly. 2006;18:288-307.

99. Alimo-Metcalfe, B., Alban-Metcalfe, J., Bradley, M., Mariathasan, J. & Samele, C. The impact of engaging leadership on performance, attitudes to work and well-being at work: A longitudinal study. Journal of Health Organization & Management. 2008;22:586-9.

100. Bass, B. M. Transformational leadership: Industry, military, and educational impact. . Mahwah, NJ: Erlbaum. 1998.

101. Alimo-Metcalfe, B. & Alban-Metcalfe, J. Leadership: Time for a new direction? Leadership. 2005;1:51-71.

102. van Breukelen, W., Schyns, B. & Le Blanc, P. Leader-member exchange theory and research: Accomplishments and future challenges. Leadership. 2006;2:295-316.

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103. Patterson, M., Warr, P. & West, M. A. Organizational climate and company productivity: The role of employee affect and employee level. Journal of Occupational & Organizational Psychology. 2004;77:193-216.

104. Xenikou, A. & Simosi, M. Organisational culture & transformational leadership as predictors of business unit performance. Journal of Management Psychology. 2006;21:566-79.

105. Yun, S., Cox, J. & Sims, H. P., Jr. Leadership & teamwork: The effects of leadership and job satisfaction on team citizenship. International Journal of Leadership Studies. 2007;2:171-93.

106. Keller, R. T. Transformational leadership, initiating structure, and substitutes for leadership: a longitudinal study of research and development project team performance. Journal of Applied Psychology. 2006;91:202-10.

107. Onyett, S. R. Revisiting job satisfaction and burnout in community mental health teams. Journal of Mental Health. 2011;20:198-209.

108. Schippers, M., West, M. A. & Dawson, J. F. Team reflexivity and innovation: The moderating role of team context. Journal of Management, in press.

109. El Ansari, W. & Phillips, C. J. The costs and benefits of participants in community partnerships. A paradox? Health Promotion Practice. 2004;5:35-48.

110. Tekleab, A. G. & Chiaburu, D. S. Social exchange: empirical examination of form and focus. Journal of Business Research. 2011;64(5):460-6.

111. El Ansari, W. Joint Working For health and Social Outcomes: The Partnership-leadership Mantra. International Journal of Leadership in Public Services. 2009;5:29-36.

112. El Ansari, W., Oskrochi, R. & Phillips, C. J. One Size Fits All Partnerships? What Explains Community Partnership Leadership Skills? Health Promotion Practice. 2010;11:501-14.

113. Davies, R., Shocolinsky-Dwyer, R., Mowat, J., Evans, J., Heslop, P., Onyett, S. & Soteriou, T. Effective involvement in mental health services: the role of assertive outreach and the voluntary sector. 2009.

Project 08/1819/215

114. Williams, K. & O'Reilly, C. Demography and diversity in organizations: A review of 40 years of research. Research in organizational behavior (Ed B. M. Staw & L. L. Cummings). 1998;20:77-140.

115. van Knippenberg, D. & Schippers, M. C. Work group diversity. Annual Review of Psychology. 2007;58:515-41.

116. Pettigrew, T. F. & Tropp, L. R. A meta-analytic test of intergroup contact theory. Journal of Personality and Social Psychology. 2006;90(751-783).

117. Pettigrew, T. F. & Tropp, L. R. When groups meet: The dynamics of intergroup contact. Philadelphia, PA: Psychology Press. 2011.

118. Rees, A., Stride, C., Shapiro, D. A., Richards, A. & Borrill, C. Psychometric properties of the Community Mental Health Team effectiveness questionnaire (CMHTEQ). Journal of Mental Health. 2001;10:213-22.

119. Lamb, B. W., Wong, H. W. L., Vincent, C., Green, C. S. A. & Sevdalis, N. Teamwork and team performance in multidisciplinary cancer teams: Development and evaluation of an observational assessment tool. British Medical Journal Quality & Safety. 2011;20:849-56.

120. McKergow, M. Leader as Host, Host as Leader: Towards a new yet ancient metaphor. International Journal for Leadership in Public Services. 2009;5:19-24.

121. Centre for Mental Health. The Economic and Social Costs of Mental Health Problems in 2009/10. Downloaded from http://www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf 2010.

122. Onyett, S. R. Working Psychologically in Teams. 2007.

123. Suchman, A. L., Sluyter, D. J., Penelope R. & Williamson, R. R. Leading change in healthcare: Transforming organisations using complexity, positive psychology & relationship-centered care. Radcliffe. 2011.

124. Obolensky, N. Complex Adaptive Leadership. Gower Publishing 2011.

125. Jackson, P. Z. & McKergow, M. The Solutions Focus. Nicholas Brealey Publishing, London. 2002.

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126. Watkins, J. M. & Mohr, B. J. Appreciative Inquiry: Change at the Speed of Imagination. San Francisco, CA: Jossey-Bass/Pfeiffer. 2001.

127. Seddon, J. Systems Thinking in the Public Sector. Axminster: Triarchy Press. 2008.

128. Huxley, P. Evans, S., Baker, C., White, J., Philpin, S., Onyett, S. & Gould, N. Integration of social care staff within community mental health teams. Final report. NIHR Service Delivery and Organisation programme. 2011.

129. Ryrie, I., Hellard, L., Kearns, C., Robinson, D., Pathmanathan, I. & O'Sullivan, D. Zoning: A system for managing case work and targeting resources in Community Mental Health Teams. Journal of Mental Health. 1997; 6(5):515-24.

130. Barker, P. & Buchanan-Barker, P. The Tidal Model: A Guide for Mental Health Professionals. London: Brunner-Routledge. 2005.

131. Parker, L. & Bevan, S. Good Work and Our Times. Report of the Good Work Commission. London Work Foundation. 2011.

132. Byrne, M. & Onyett, S. R. Teamwork Within Mental Health Services In Ireland Resource Paper. . Mental Health Commission 2010.

133. Ozcelik, H., Langton, N. & Aldrich, H. Doing Well and Doing Good. The relationship between leadership practices that facilitate a positive emotional climate and organizational performance. Journal of Managerial Psychology. 2008; 23, 186-203.

134. Herzberg, F. The Motivation to Work. New York: John Wiley and Sons. 1959.

135. Clark, J. On the bounce: Understanding mental health systems in the North West. http://www.northwest.nhs.uk/document_uploads/MentalHealthNews_July09/OnTheBounce_UndersMHSysFINAL_2Sept08.pdf. 2008.

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Appendix 1

Ethical and R&D approvals and difficulties encountered

1.1 Ethical Approval for stages 1 and 2

Following required amendment to the original ethics application to the South Staffordshire Local REC made on 9th June 2009, the resubmission was made to the Black Country REC from which a favourable opinion to proceed with Stages 1 and 2 of the project (see below) was received on 24th November 2009. (Stage 3 of the project – see below - was the subject of a separate NHS REC application.)

1.2 R&D Approval for stages 1 and 2

Following receipt of the favourable opinion from the REC on 24th November 2009 (see above) and the advice of the project's Lead CLRN (West Midlands South Comprehensive Local Research Network) for R&D approval purposes we decided that Stages 1 and 2 of the project should be designated the then new (introduced in April 2009) PIC status rather than the alternative Research Site status. At this time, we planned confirming the dates of the Stage 1 Workshops which we hoped to complete by the end of February 2010 so that the Stage 2 questionnaire survey could begin in May. In an attempt to achieve these plans, the research team immediately completed the IRAS R&D forms with the understanding that the approval process for PIC studies in each participating Trust would be simpler and quicker than if the studies had been designated Research Site status as intimated by the following from the NHS IRAS website:

> *"Research sites, as defined in IRAS, are organisations responsible for participant-related research procedures specified in the protocol including recruitment and informed consent. The following are not considered to be research sites: Clinicians or clinical units making referrals to the research team. Research units undertaking support functions, e.g. project management, site monitoring, data analysis or report writing. The purpose of the guidance in IRAS is to clarify that NHS organisations responsible for locations from which clinicians refer service users are not responsible for providing indemnity for the research activity. That is the responsibility of the site conducting protocol-driven procedures. The NHS organisation responsible for the Participant Identification Centre is expected to review the request to refer service users (including any resource implications and other issues such as data protection) and agree to this."* Accessed at: https:/www.myresearchproject.org.uk/help/faqs.aspx#Participant Identification Centres_Q1 15th July 2011.

In short, the R&D processes for non-clinical studies that do not require researchers to enter NHS premises for the purposes of data collection from staff or service users should be "quick and simple". This is because the only role

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Trusts play in them is identifying participants and passing on this information to the researchers.

Within days of the project details being posted on the CLRN website numerous e-mail and telephone complaints about the PIC status of the project were received by the researchers from Mental Health Research Network Hub Managers and NHS R&D and other staff. To illustrate, two such complaints that we received are:

> *"I can't see how the Trusts can be selected as PIC sites for this study. The definition of a PIC site is that all the interventions (including the completion of questionnaires) is undertaken outside of the Trust which doesn't seem to be the case here. There is also the issue of service support costs and accrual – (e.g. if a Trust is used as a PIC site they don't get any accrual or service support costs) which would be extremely problematic for this study as you will be asking Trust staff to complete questionnaires. For these reasons many of our Trusts will not act as a PIC"* (Hub Manager by e-mail 27th November 2009).

> *"My understanding was that if a site consents patient is not eligible to be a PIC site. Where PIC sites are the correct designation, unfortunately no (named) Trusts are willing to participate"* (Hub Manager by e-mail 27th November 2009).

Over the ensuing weeks there was much correspondence and discussion between staff in our Lead CLRN, Hub Managers and staff in our selected Trusts about the meaning of PIC status before all of our involved Trusts finally agreed in early March 2010 to participate in the study given its approved PIC designation. As an officer in our Lead CLRN remarked: "There much misunderstanding in some Trusts about PIC studies."

However, this delay meant that the last of the Stage 1 workshops occurred on 15th July 2010, which in turn meant that we could not launch the Stage 2 questionnaire survey until 1st October that year. Anticipating the effect of these delays on progress with the project, in Spring 2010 we successfully negotiated with our SDO funding body a six-month unfunded extension to the project and the removal of the need to complete its intended Stage 4.

1.3 Ethical approval for stage 3

The application to proceed with data collection for this stage of the project for the five selected trusts during the period from 1st February to 31st July 2011 was submitted to the Birmingham East, North & Solihull REC on 14th June 2010, which notified us of its favourable opinion on 28th July 2010.

1.4 R&D Approval

Following receipt of the favourable opinion from the REC on 28th July 2010 (see above) we began the process of obtaining R&D approval for this Research Site study from each Trust with a view to starting data collection on 1st February 2011. Research passport applications for three of the authors (JD, PBN and JR) were completed and handed over to an Aston University colleague on 8th September 2010, but their onward transmission from the university to our Lead CLRN was delayed until 14th November of that year. On behalf of all of the Trusts our Lead CLRN swiftly checked and approved the applications and issued each of us with a Letter of Access, which is all that she confirmed is necessary for the type of non-clinical study that we were to undertake. Two of our other Trusts made a similar decision and also issued us with Letters of Access. However, apparently unnecessarily, another Trust decided to issue us with Honorary Contracts whilst the fifth Trust decided to issue us with Research Passports both of which require the application of more stringent and lengthy checks. The last of these documents were not received until 28th January 2011, that is, three days before Stage 3 data collection was scheduled to begin. We conclude from these differences of opinion that there is much confusion and misunderstanding in some Trusts' R&D departments about the Research Passport application and approval processes and what kind of documentation it is most appropriate to issue for, at least, studies of our kind.

We went through the Research Passport application process again for a fourth researcher (and author - GH) as soon as she was appointed on 16th December 2010 to start work on the project on 30th January 2011.

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Appendix 2

Questionnaire combining ATPI and CMHT effectiveness scales

Team Code: _____

TEAM WORKING IN MENTAL HEALTH

This survey is about how you view **your work team**.

This is **not a test**. There are no "right" or "wrong" answers. We are interested in your personal views about the team. The biographical questions towards the end of the inventory are to enable us to compare the views of different groups of people, we will not use this information to identify you personally at any time.

I

Some questions about the survey

Who will see my answers?

The information you give is totally confidential. The information you give will be processed by independent consultants. Results will be presented in a way that completely protects your anonymity and confidentiality.

How long will it take?

The questionnaire will take about 25-30 minutes to complete.

How do I fill in this questionnaire?

Please read each question carefully and give your immediate response by ticking the box which best matches your views. We are interested in **your views** about the team in which you work. Please answer all questions as openly and honestly as possible.

Which team should I be thinking about when answering the questions?

Please answer all the questions in relation to the team described in the box below and in the covering invitation which accompanies this questionnaire

---

Name of Community Mental Health Team

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About the team you work in

The questions on this page aim to give us a broad view of the type of team in which you work

How many people are there in your team (the core members)?

3 - 5 ☐   6 - 9 ☐   10 -15 ☐   More than 15 ☐

How many teams do you work in?

1 ☐   2 ☐   3 ☐   4 ☐   5 ☐   More than 5 ☐

Which other teams within the trust do you personally have to communicate/liaise with in the course of your work? (Please list the team names)

_____   _____

_____   _____

_____   _____

If you work as part of other teams within this trust, please indicate which these are below

_____   _____

_____   _____

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About the characteristics of your team

The following statements describe certain features and characteristics that may be present in a work team. Please put a cross in the box that, in your view, most represents the situation in your team.

Team Inputs

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
1. Every team member puts in sufficient effort to get the job done.	☐	☐	☐	☐	☐
2. Members of my team have to communicate closely with each other to get the job done.	☐	☐	☐	☐	☐
3. People in this organisation are enthusiastic about the idea of working in teams.	☐	☐	☐	☐	☐
4. It is 'everyone for themselves' in this organisation.	☐	☐	☐	☐	☐
5. Our team members have the right skills needed to do the team's work.	☐	☐	☐	☐	☐
6. The team has about the right number of people to do the task well.	☐	☐	☐	☐	☐
7. The team is given the financial, technical and material resources it needs to achieve its objectives.	☐	☐	☐	☐	☐
8. The team is kept well informed about any change in organisational policy and the reasons behind such changes.	☐	☐	☐	☐	☐
9. In this team we set our own goals.	☐	☐	☐	☐	☐
10. We have a lot of freedom in how to do the team's work.	☐	☐	☐	☐	☐
11. This organisation strongly believes in the importance of training for team working.	☐	☐	☐	☐	☐
12. All team members are strongly motivated to perform well.	☐	☐	☐	☐	☐
13. We have to coordinate our work tightly in this team.	☐	☐	☐	☐	☐
14. Team working is seen in this organisation as a gimmick or fad.	☐	☐	☐	☐	☐
15. We usually know how well we are achieving the team goals.	☐	☐	☐	☐	☐
16. The team has all the skills we need to do the team's task.	☐	☐	☐	☐	☐
17. The team is given the resources it needs to do the work.	☐	☐	☐	☐	☐
18. Communication of information to the team by the organisation is excellent.	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
19. The team does not get the information it needs from the organisation so it can plan its work.	☐	☐	☐	☐	☐
20. We decide as a team who will do what in the team.	☐	☐	☐	☐	☐
21. As a team, we believe in our ability to perform the team's task well.	☐	☐	☐	☐	☐
22. Team members are strongly encouraged to develop their team working skills in this organisation.	☐	☐	☐	☐	☐
23. Everyone in the team works hard to achieve the team goals.	☐	☐	☐	☐	☐
24. The team task cannot be achieved without the contribution of every team member.	☐	☐	☐	☐	☐
25. There is a genuine spirit of co-operation in this organisation.	☐	☐	☐	☐	☐
26. The team gets clear feedback on its performance.	☐	☐	☐	☐	☐
27. The team has the right mix of people.	☐	☐	☐	☐	☐
28. The team is given a task to perform but not the material resources it needs to do the job.	☐	☐	☐	☐	☐
29. Enough effort is made by the organisation to understand the opinions and thinking of our team.	☐	☐	☐	☐	☐
30. The team's task is important for the organisation's success.	☐	☐	☐	☐	☐
31. We are free to decide how to carry out the team's task.	☐	☐	☐	☐	☐
32. Team members believe we can achieve the team goals.	☐	☐	☐	☐	☐
33. This organisation only gives people the minimum training needed to work in a team.	☐	☐	☐	☐	☐
34. The team has a complete and challenging task to perform.	☐	☐	☐	☐	☐

Team Processes

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
35. We have strong disagreements about how to perform the team's task.	☐	☐	☐	☐	☐
36. The methods used by the team to get the job done are often discussed.	☐	☐	☐	☐	☐
37. The team often reviews its objectives.	☐	☐	☐	☐	☐
38. Team members are generally warm and supportive of each other.	☐	☐	☐	☐	☐
39. Heated debates about how to do our work in the team are rare.	☐	☐	☐	☐	☐

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	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
40. We regularly discuss whether the team is working effectively together.	☐	☐	☐	☐	☐
41. Patient needs come first in this team.	☐	☐	☐	☐	☐
42. We know we can rely on one another in this team.	☐	☐	☐	☐	☐
43. Team members sometimes have unpleasant or heated conflicts with each other.	☐	☐	☐	☐	☐
44. We have lively debates about how best to do this work.	☐	☐	☐	☐	☐
45. People in the team are quick to offer help to try out new ways of doing things.	☐	☐	☐	☐	☐
46. Everyone in the team contributes to decision making.	☐	☐	☐	☐	☐
47. There is often conflict over how best the team can achieve its objectives.	☐	☐	☐	☐	☐
48. How well we communicate information is often discussed.	☐	☐	☐	☐	☐
49. We make patient the top priority in this team.	☐	☐	☐	☐	☐
50. There is a feeling of trust and safety in this team.	☐	☐	☐	☐	☐
51. There is little interpersonal conflict in this team.	☐	☐	☐	☐	☐
52. There is a climate of constructive debate in this team.	☐	☐	☐	☐	☐
53. In this team we seek out and support ideas for new services / products.	☐	☐	☐	☐	☐
54. We all influence the final decisions made in the team.	☐	☐	☐	☐	☐
55. In this team we know what we are trying to achieve.	☐	☐	☐	☐	☐
56. We are careful to keep each other informed about work issues.	☐	☐	☐	☐	☐
57. We are committed to doing an excellent job in this team.	☐	☐	☐	☐	☐
58. We support each other's ideas for new and improved ways of doing the team's work.	☐	☐	☐	☐	☐
59. We agree in the team about what are our team objectives.	☐	☐	☐	☐	☐
60. We meet together frequently to ensure effective communication and co-operation.	☐	☐	☐	☐	☐
61. Team members are committed to achieving the team's objectives.	☐	☐	☐	☐	☐
62. We constructively discuss errors and mistakes in the team.	☐	☐	☐	☐	☐

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Leadership

The following section asks about leadership in your team.

The leader of my team...
(please mark the box most applicable to your opinion)

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
63. ...ensures we have all the resources we need to do the team's work effectively.	☐	☐	☐	☐	☐
64. ...helps the team organise and co-ordinate work activities to avoid delays, duplication of effort and wasted resources.	☐	☐	☐	☐	☐
65. ...encourages the team to look at problems from a different perspective.	☐	☐	☐	☐	☐
66. ...checks the team's work progress against plans to see if it is on target.	☐	☐	☐	☐	☐
67. ...encourages us to work cooperatively with other teams and departments.	☐	☐	☐	☐	☐
68. ...helps the team with acquiring the resources that are needed to carry out its work.	☐	☐	☐	☐	☐
69. ...ensures that all team members can contribute their knowledge and expertise to the decisions made by the team.	☐	☐	☐	☐	☐
70. ...encourages the team to learn from mistakes.	☐	☐	☐	☐	☐
71. ...checks on the quality of the work carried out by the team.	☐	☐	☐	☐	☐
72. encourages the team to work collaboratively with other teams.	☐	☐	☐	☐	☐
73. ...makes clear to the team what results are required.	☐	☐	☐	☐	☐
74. ...recognises good performance or extra effort made by team members.	☐	☐	☐	☐	☐
75. ...is available to team members to discuss a problem or particular issue.	☐	☐	☐	☐	☐
76. ...supports team members' ideas for new and improved ways of doing things.	☐	☐	☐	☐	☐
77. ...treats each team member as an individual with different needs, abilities and aspirations.	☐	☐	☐	☐	☐
78. ...presents feedback to the team in a helpful manner and helps them to develop a workable plan for improvement.	☐	☐	☐	☐	☐
79. ...provides encouragement and support when the team has a difficult or stressful task.	☐	☐	☐	☐	☐

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Community Mental Health Team Effectiveness

	Strongly disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
80. When necessary, my team contacts other teams and agencies to share information about patients.	☐	☐	☐	☐	☐
81. Helping patients improve their sense of well-being is a major goal of my team.	☐	☐	☐	☐	☐
82. Professional boundaries between patients and staff in my team are poorly defined.	☐	☐	☐	☐	☐
83. My team encourages patients to take the next step on the path to their recovery.	☐	☐	☐	☐	☐
84. My team's referral processes are unclear to many of us.	☐	☐	☐	☐	☐
85. My team helps patients to build positive aspects of their lives.	☐	☐	☐	☐	☐
86. Sharing knowledge and experience of good practice is not a feature of my team's work.	☐	☐	☐	☐	☐
87. Regardless of professional background, my team members are willing to learn from one another.	☐	☐	☐	☐	☐
88. My team does not involve patients in developing their own care plans.	☐	☐	☐	☐	☐
89. My team explores new ways of providing patient care.	☐	☐	☐	☐	☐
90. My team acknowledges that one size does not fit all patients.	☐	☐	☐	☐	☐
91. My team offers information about services to carers.	☐	☐	☐	☐	☐
92. My team does not communicate effectively with other mental health teams in the Trust.	☐	☐	☐	☐	☐
93. In my team, relationships with patients are based on openness.	☐	☐	☐	☐	☐
94. Patients rarely receive care from the same members of my team.	☐	☐	☐	☐	☐
95. To help ensure continuity of care my team is flexible in managing its workload.	☐	☐	☐	☐	☐
96. Taking patients' views into account is important in my team.	☐	☐	☐	☐	☐
97. There is a lack of mutual respect between the members of my team.	☐	☐	☐	☐	☐
98. In my team, we listen to patients and work collaboratively with them.	☐	☐	☐	☐	☐
99. Carers are not seen as very important by my team.	☐	☐	☐	☐	☐

Team Outputs

	Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree
100. Managers often praise the quality of our work.	☐	☐	☐	☐	☐
101. I would be sad if I had to leave this team.	☐	☐	☐	☐	☐
102. I would like to keep working in this team.	☐	☐	☐	☐	☐
103. We develop new and improved ways of working.	☐	☐	☐	☐	☐
104. We find new ways of meeting patient needs.	☐	☐	☐	☐	☐
105. We never have disagreements with members of other teams or departments about tasks or projects we are working on.	☐	☐	☐	☐	☐
106. We rarely have conflicts with other teams or departments about who should do what when we work with them.	☐	☐	☐	☐	☐
107. We work closely with other teams and departments in the organisation.	☐	☐	☐	☐	☐
108. The team is often told by others that it is performing well.	☐	☐	☐	☐	☐
109. I have a strong attachment to my colleagues in this team.	☐	☐	☐	☐	☐
110. I am satisfied with the recognition I receive from team colleagues for my contribution to the team.	☐	☐	☐	☐	☐
111. We develop new products and services.	☐	☐	☐	☐	☐
112. We develop innovative ways of accomplishing targets and objectives.	☐	☐	☐	☐	☐
113. There is no friction between our team and other teams or departments in the organisation.	☐	☐	☐	☐	☐
114. I am satisfied with the amount of responsibility I am given in the team.	☐	☐	☐	☐	☐
115. There is a high level of co-operation and trust between our team and other teams and departments in the organisation.	☐	☐	☐	☐	☐
116. I am satisfied with the support I receive from team colleagues.	☐	☐	☐	☐	☐
117. This team is consistently told that it achieves or exceeds its goals.	☐	☐	☐	☐	☐
118. I am satisfied with the opportunities to discuss work-related problems in an open manner in the team.	☐	☐	☐	☐	☐
119. I am satisfied with the attention paid to the suggestions I make in the team.	☐	☐	☐	☐	☐
100. I am satisfied with the way in which conflicts are resolved.	☐	☐	☐	☐	☐

Biographical Details

This part of the questionnaire asks for details about you and your work. This information will be used to enable us to compare the views of different groups of people – **it will not be used to identify you personally at any time.**

1.   My gender is...

Female   ☐

Male   ☐

2.   My age is ....

16-29   ☐

30-39   ☐

40-49   ☐

50-59   ☐

60+   ☐

3.   My ethnic group is...

White	Asian / Asian British	Mixed
☐ British	☐ Indian	☐ White and Black Caribbean
☐ Irish	☐ Pakistani	☐ White and Black African
☐ Other White background	☐ Bangladeshi	☐ White and Asian
	☐ Other Asian background	☐ Other mixed background
Black / Black British	**Chinese**	**Other ethnic group**
☐ Caribbean	☐ Chinese	☐ Any other ethnic group
☐ African		Please specify
☐ Other Black background		

4.   I have worked in my present position for...   _____ Years_____ Months

5.   I have worked in this team for...   _____ Years_____ Months

6.   My job type is (please mark only one):

☐ Admin/clerical staff	☐ Support Time Recovery (STR) worker
☐ Community Psychiatric Nurse (CPN)	☐ Nurse (other than CPN)
☐ Clinical Psychologist	☐ Other medical practitioner
☐ Occupational Therapist	☐ Any other occupational group (please specify)
☐ Psychiatrist	_____
☐ Social Worker	

7.   Are you the leader of this team?   Yes ☐   No ☐

Thank you for taking time to give us your views

Appendix 3

Letter of invitation to team leader/manager for his/her team to participate in the Stage 2 questionnaire survey

Aston University

Aston Triangle

Birmingham B4 7ET

Tel +44 (0) 121 204 3000

www.abs.aston.ac.uk

Date:

Dear *name of team leader/manager*,

Multi-Professional Team Working (MPTW) in Mental Health Care Project: Stage 3

As I am sure you are aware, your Mental Health Team has recently participated in a questionnaire survey for Stage 2 of this project being conducted by Aston University. The overall aim of this research is to identify the main factors that ensure that MPTW is effective in delivering healthcare and improving health outcomes for service users. The project is funded by the NIHR Service Delivery and Organisation programme and is intended to have an important impact on the way in which Community Mental Healthcare is delivered by teams in the NHS.

When you were initially invited to participate in the Stage 2 survey, you may recall that we said that there was a possibility that your team may be invited to take part in Stage 3 of the project, which will look more closely at the fine grained team processes, and contextual, professional and institutional incentives and barriers to MPTW. **Based on the results of the survey we are inviting you and your team, along with 19 other CMHTs in England, to participate in this Stage 3 of the project.**

Your team's participation would involve the following:
- **One-to-one interviews with three to six members of your team** (preferably one team member from each major professional group). The interviews will take place on Trust premises at your convenience, will be

conducted by a member of the research team, and will last no longer than 45 minutes.

- **Observation of a multi-disciplinary team meeting** by a member of the research team.
- **One-to-one interviews with three of your team's service users and carers (at least one of each).** Here we would ask that your team identifies suitable service users and carers and gives them Information Sheets and Consent Forms supplied by us and ask them, after at least a 48 hour cooling-off period, to let you know whether or not they would like to participate in the study. Again, the interviews will take place on your Trust's premises during the working day. They will be conducted by a member of the research team, and most will no longer than 45 minutes. Service users and carers will be paid £19.80 per hour for their participation, and their travel and subsistence will also be reimbursed.
- A slight delay in the return of your team feedback report from the Stage 2 survey until after the Stage 3 interviews and observation have been complete. This will ensure that the feedback does not interfere with your day-to-day team dynamics while we are conducting further research, thus ensuring that the information you provide us is reliable, accurate and not unduly influenced by the information in the report.

By taking part in this Stage 3 you will not only receive the team feedback report based on your questionnaire results from Stage 2, but we will also provide you with **an additional anonymised report of our more detailed findings and conclusions about your team** based on the interviews and observations once from Stage 3.

Please find attached a Participant Information Sheet and Consent Form that members of your team will be asked to sign in order to take part in this next stage of research. We would like to start conducting interviews and observations with each team as soon as possible but at your convenience. We hope to start collecting data with your team from 1st February 2011.

We would greatly appreciate it if you could let us know whether you would like to take part in Stage 3 of this project within the next 10 working days.

Your participation would be highly valued by the research team and would provide a crucial insight into the day-to-day workings of CMHTs, the challenges they face, and the experiences of their service users and carers. If you have any questions, please do not hesitate to contact me.

I look forward to hearing from you.

Yours sincerely,

Paul Naylor, PhD

Senior Research Fellow

Institute for Health Services Effectiveness

Aston Business School

Birmingham

Tel: 0121 204 3316

E-mail: P.B.Naylor@aston.ac.uk

Appendix 4

MPTW Stage 3 Invitation, Information sheet and Consent Form for Service Providers

Aston Business School

Aston University

Aston Triangle

Birmingham

B4 7ET

Address and date to be inserted

Dear Colleague,

Multi-Professional Team Working (MPTW) in mental health care research project: Stage 3

We invite you to take part in this stage of the project. Before making your decision about whether or not to participate please read the following information, which has been in anticipation of questions that you may have. However, please let us know if there are any other questions that you have or about our answers below.

Q   What is this project about?

A   The overall aim of this project to find ways in which the services provided by all types of Community Mental Health Teams (CMHTs) to their service users and carers might be improved. It is a three-stage project. Stage 1 involved a series of workshops for service providers, service users and carers with the purpose of finding out from their perspectives what good team working is and is not, and how it can improved.

The findings were then fed in to the questionnaire used in a large-scale survey of over 100 multi-disciplinary CMHTs in Stage 2. This questionnaire was designed to identify the factors from the respondents' viewpoints that have most influence on team working effectiveness.

In this Stage 3, we are inviting 20 of the multi-disciplinary teams involved in the Stage 2 questionnaire survey to be studied in greater depth. For each of these teams, a project researcher would like to observe and make notes of a team meeting, and conduct individual interviews with three to six team members and three service users and carers (at least one of each) known by the team.

Q   What will be involved if I agree to participate in the study?

A   Once you and your team members have expressed interest participating in this study, we will ask you (or members of your team) to give three service users and carers (at least one of each) currently or recently associated with your team information sheets similar to this one about the project. These people will be asked to let your team know whether or not they wish to participate in an interview with a member of the research team, and we ask that the process continues until there are three volunteers. Once your team has identified these volunteers we will ask you to ask them to contact us so that we can arrange for their interviews to take place on NHS premises.

We will also ask your team to identify three to six of its members (each from a different professional group) who are willing to be individually interviewed each for no more than 45 minutes and to provide us with contact details so that we can arrange individual interviews with them. We will also arrange with you the observation of a multi-disciplinary team meeting.

Q   How will information in the individual interviews and the team meeting observation be recorded?

A   Only hand written notes of your team meeting observation will be made – they will not be audio-recorded. No service user or staff names will be recorded in the written notes. We would prefer to audio-record individual interviews but for any interviewee who objects to this we will only make hand written notes. All audio recordings and hand written notes will be securely kept in Aston University and only members of the research team will have access to them. In reports of the research direct quotations of what people have said in meetings and interviews may be written, but if so, they will be written in such ways that the speaker's identity is completely anonymised.

Q   What are the benefits of taking part?

A   At the end of the research with your team, we will provide a brief anonymised report of our findings and conclusions about the team. On conclusion of the study, we will provide your team with a brief report of the whole study. We hope that these reports will enable your team to reflect on and, maybe, improve its practice for the benefit of its service users and carers. Please note that your team and your team only, will receive a copy of this report. Service users and carers who are associated with your team, and take part in interviews for this project, will not receive a copy of this report.

Q   What are the possible disadvantages and risks of taking part?

A   We do not anticipate that this project will upset or disadvantage you in any way. However, if you do experience any distress please let your team leader or manager or a member of your team know and discuss it with him/her.

Another possible disadvantage of participating in this study is that your team's performance report from Stage 2 of the project will be withheld from both yourselves and the researcher(s) who interview/observe you, until after all of the information about the team for this Stage 3 study has been collected. This is so that the outcomes of the Stage 2 report can have no influence on the information that we collect in this study. However, this will be compensated by providing your team with a much more detailed report about your results from the Stage 3 interviews and observations.

Q   Can I withdraw from the study at any time?

A   Yes. You simply need to let a member of the research team know that you are withdrawing from the study and you do not need to provide any reason for doing so.

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Q   Will the information obtained in the study be confidential?

A   Yes. The only people who will have access to information about your team will be members of the research team. This information will not be given to any unauthorised body, and it will be kept securely in Aston University. By July 2015 the information will be safely destroyed. For the purposes of any publication, all research data provided by you and other members of your team will be anonymised in such ways as to make it impossible for anybody, including members of your team and its service users and carers, to identify you, your team or Trust.

Q   Who has approved the project?

A   A NHS Research Ethics Committee has approved the study.

Q   What if I wish to complain about the way in which this study has been conducted?

A   Please contact: the Independent Complaints Advocacy Services West Midlands on Tel: 0845 120 3748.

If you have any other questions please do not hesitate to contact one of us and we will do our best to answer them.

Yours sincerely,

Mr Jeremy Dawson, Senior Research Fellow. Tel: 0121 204 3075. E-mail: j.f.dawson@aston.ac.uk

Dr Paul Naylor, Senior Research Fellow. Tel: 0121 204 3287. E-mail: p.b.naylor@sheffield.ac.uk

Ms Joanne Richardson, Research Fellow. Tel: 0121 204 4902. E-mail: j.richardson3@aston.ac.uk

Consent Form

This form is for your information before the event; additional copies will be supplied on the day.

Project: Multi-Professional Team Working in mental health care project - Stage 3

Name of researcher:

1. I confirm that I have read and understand the information sheet dated 09.06.10 Version 1 for the above study. I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily.

Please initial   Yes   No

☐   ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without my legal rights being affected

Please initial   Yes   No

☐   ☐

3. I understand that hand written notes of a team meeting that I attend may be taken, and/or an audio-recording of my individual interview will be made (unless I would prefer hand written notes to be made). I understand that these records will be anonymised and kept securely in Aston University.

Please initial   Yes   No

☐   ☐

4. I understand that direct quotations of what I say may be used in reports and publications of the study, but that if this happens my identity will not be revealed in any way.

Please initial ONE box

a) I agree to my quotations being used   ☐

b) I do not agree to my quotations being used   ☐

5. I agree to take part in the above study.

Please initial   Yes   No

☐   ☐

6. I understand that relevant sections of data collected during the study may be looked at by researchers in Aston Business School. I give my permission for these individuals to have

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access to my data (without knowing my name) in this study.

Please initial   Yes   No

☐   ☐

_____   _____   _____

Name of Service Provider   Date   Signature

_____   _____   _____

Name of Researcher   Date   Signature

When completed, one copy is to be kept by the participant and two by the research team.

Appendix 5

Letter of invitation to service user/carer to participate in the Stage 3 qualitative study

Aston University

Aston Triangle

Birmingham

B4 7ET

+44 (0)121 204 3000

Address and date to be inserted

Dear Service user or Carer,

Multi-Professional Team Working (MPTW) in mental health care project: Stage 3

We invite you to take part in this stage of the project. Before making your decision about whether or not to participate please read the following information, which has been written in anticipation of questions that you may have. However, please let us know if there are any other questions that you have, or about our answers below.

Q   What is this project about?

A   The overall aim of this project to find ways in which the services provided by all types of Community Mental Health Teams to their users and carers might be improved. It is a three-stage project. Stage 1 involved a series of workshops for service providers, service users and carers with the purpose of finding out from their perspectives what good team working is and is not, and how it can improved.

The findings were fed in to the questionnaire used in a large-scale questionnaire survey of over 100 Community Mental Health Teams (CMHTs) in Stage 2. This questionnaire was designed to identify the factors from the respondents' viewpoints that have most influence on team working effectiveness.

In this Stage 3, we are inviting 20 of the teams involved in the Stage 2 survey to be studied in greater depth. For each of these teams, a project researcher would like to observe and make notes of a team

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meeting, and conduct individual interviews with three to six team members, as well as three service users and carers (at least one of each) known to the team.

Q   What will be involved if I agree to participate in the study?

A   Once your Community Mental Health Team has confirmed by signing a consent form that they are willing to participate in this study, they have been asked to give you this letter and consent form (appended). We ask you to let a member of your team know as soon as possible whether or not you wish to participate in this study. If you do wish to participate, please contact one of us directly so that we can arrange for your interview to take place. All interviews will take place on the Trust's premises to which your team belongs during working hours (between 9am and 5pm).

Q   How will information in my interview be recorded?

A   Your interview will be audio-recorded, unless you would prefer hand written notes to be made. No service user or staff names will be recorded in the written notes. All recordings and notes will be securely kept in Aston University and only members of the research team will have access to them.

Q   What are the benefits of taking part?

A   You will be paid £19.80 per hour for your time in being interviewed. The simplest way in which this payment can be made is through high street shopping vouchers, which can be used in many retail outlets. Unlike payment by cash or cheque, payment by vouchers is not taxed. However, the choice of how you wish to be paid is yours. You will also be reimbursed all second class travel expenses incurred in attending the interview.

Q   What are the possible disadvantages and risks of taking part?

A   We do not anticipate that this project will upset or disadvantage you in any way. However, if you do experience any distress please let a member of your team or your GP or another medical practitioner know and discuss it with him/her.

Q   Can I withdraw from the study at any time?

A   Yes. You simply need to let a member of the research team know that you are withdrawing from the study and you do not need to provide any reason for doing so.

Q   Will the information obtained in the study be confidential?

A   Yes. The only people who will have access to information about you and your team will be members of the Aston University research team. This information will not be given to any unauthorised body, and it will be kept securely in Aston University. By July 2015 the information will be safely destroyed. For the purposes of any publication, all research information provided by you will be anonymised in such ways as to make it impossible for anybody, including members of your team, to identify you or your team.

Q   Who has approved the project?

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A   An NHS Research Ethics Committee has approved the study.

Q   **What if I wish to complain about the way in which this study has been conducted?**

A   Please contact: the Independent Complaints Advocacy Services West Midlands on Tel: 0845 120 3748.

If you have any further questions please do not hesitate to contact one of us and we will do our best to answer them.

Yours sincerely,

Mr Jeremy Dawson, Senior Research Fellow. Tel: 0121 204 3075. j.f.dawson@aston.ac.uk

Dr Paul Naylor, Senior Research Fellow. Tel: 0121 204 3287. p.b.naylor@sheffield.ac.uk

Ms Joanne Richardson, Research Fellow, Tel: 0121 294 4902. j.richardson3@aston.ac.uk

Consent Form

This form is for your information before the event; additional copies will be supplied on the day.

Project: Multi-Professional Team Working in mental health care project – Stage 3

Name of researcher:

1. I confirm that I have read and understand the information sheet dated 09.06.10 Version 1 for the above study. I have had the opportunity to consider the information, ask questions and I have had these answered satisfactorily.

Please initial   Yes No

☐ ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without my legal rights being affected

Please initial   Yes No

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3. I understand that an audio-recording of my interview will be made (unless I would prefer hand written notes to be made). I understand that these records will be anonymised and kept securely in Aston University.

Please initial   Yes   No

4. I understand that direct quotations of what I say may be used in reports and publications of the study, but that if this happens my identity will not be revealed in any way.

Please initial ONE box

a) I agree to my quotations being used

b) I do not agree to my quotations being used

5. I agree to take part in the above study.

Please initial   Yes No

6. I understand that relevant sections of data collected during the study may be looked at by researchers in Aston Business School. I give my permission for these individuals to have access to my data (without knowing my name) in this study.

Please initial   Yes No

_____   _____   _____

Name of Service user/Carer   Date   Signature

_____   _____   _____

Name of Researcher   Date   Signature

When completed, one copy is to be kept by the participant and two copies by the research team.

Appendix 6

MPTW Stage 3 interview schedule for Service Providers

Introduction along the lines of ...
- Intro of self as interviewer – who, what, where, etc.
- Thanks for agreeing to be interviewed.
- Assure re confidentiality and anonymity. (Only exception might be disclosure of a crime - if that happens will inform what intend doing about this)
- Obtain written consent to proceed.
- Verbal consent to record.
- Any questions to ask before starting?
- Shall I turn on the recorder?

NB Semi-structured interviewing; questions/topics not to be followed slavishly; clarification to be sought and probes used as appropriate; illustrations to be sought as necessary

Biographical information
- Professional background / career to date
- Length of time working in MH care
- Type of CMHT work in / Length of time in this team / Other teams worked in.
- Previous experience of other CMHTs.
- Describe a typical day in your current role

Team goals
- What are the major goals of the team? → *Factors promoting/hindering*

Improved service user well-being
- Extent team helps service users build positive aspects of their lives → *Factors promoting/hindering*
- Extent team encourages service users to take next steps on path to getting better → *Factors promoting/hindering*
- Extent taking service users' views into account is important to team → *Factors promoting/hindering*
- Extent service users involved in developing own care plans → *Factors promoting/hindering*

Therapeutic relationships with service users

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- Extent professional boundaries between service users and staff are clearly defined → *Factors promoting/hindering*
- Extent relationships with service users are based on openness → *Factors promoting/hindering*
- Extent service users are listened to and worked with collaboratively → *Factors promoting/hindering*

Creative problem solving
- Extent team looks for tailored solutions/treatment for service users → *Factors promoting/hindering* Extent team explores new ways of providing service user care → *Factors promoting/hindering*
- Extent team shares knowledge and experience of good practice → *Factors promoting/hindering*

Continuous care
- Extent of continuity of service user care within team → *Factors promoting/hindering*
- Extent of flexibility in managing workload within team to ensure continuity of care → *Factors promoting/hindering*
- Extent to which team liaises/shares information about service users with other teams/agencies → *Factors promoting/hindering*

Inter-team working
- Extent of clarity of team's referral processes → *Factors promoting/hindering*
- Extent team communicates effectively with other mental health teams → *Factors promoting/hindering*

Respect between professionals
- Extent of mutual respect between members of team → *Factors promoting/hindering*
- Extent team members willing to learn from one another regardless of professional background → *Factors promoting/hindering*

Responsiveness to carers
- Extent team sees carers as important → *Factors promoting/hindering*
- Extent team offers carers information about services → *Factors promoting/hindering*

Organisational context
- Extent to which the team has the appropriate/adequate resources to do its work
- Capacity of the team to respond to the demands placed on it
- Adequacy of the skills/professional mix/balance within the team
- Extent to which the Trust and the team agree on issues of resources, skills mix, team role, team processes → *Ways disagreements resolved*

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- Extent of support offered by Trust/LA re HRM, training
- Whether the team/senior management/the Trust has introduced/implemented/put in place any practices/processes/procedures (up to 2 years previously) that has changed/affected the way the team works → *if so, why this was done → what the outcome was/how far the intended effect was achieved*

General
- Whether team meet regularly → *purpose of meetings → regularity/frequency of meetings → value of meetings in promoting service user care*
- Biggest strength of team → *illustration of this → reasons for this*
- What the team could do better → *illustration of this → possible remedy for this*
- Any advice would give to team leader, to help them do their job better
- Whether likes working in this team → *reasons why/why not*

Other
- Any other information about team and its work

That's the end. Many thanks for your help.

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Appendix 7

MPTW Stage 3: Interview schedule for Service users/Carers

Introduction along the lines of …

- Intro of self as interviewer – who, what, where, etc.
- Many thanks for agreeing to be interviewed
- Assure that without prejudice: questions can be declined; interview can be stopped at any time; recording can be destroyed in the interviewee's presence
- Assure re confidentiality and anonymity (Only exception might be disclosure of a crime; if that happens will inform what intend doing)
- Obtain written consent to proceed
- Obtain verbal consent to record
- Any questions before starting?
- Shall I turn on the recorder?

NB Semi-structured interviewing and so questions/topics not to be followed slavishly; clarification to be sought ; probes used as appropriate; illustrations sought as necessary

Contextual information

- When did this episode of community mental health care start?
- Which care professionals are involved in the care (roles, not names)?
- Which of the care professionals is your care co-ordinator?
- How did you (or your service user) come to be referred? (*Probe around service user's pathway through the local systems of care*)
- Have you had other episodes of community mental health care? If so, were these with the same service/team?

Improved service user well-being

- Extent this appears a major goal of the care received
- Extent service user helped to build positive aspects of their life
- Extent service user encouraged to take next steps on path to getting better
- Extent service user's views taken into account
- Whether service user has a care plan → Extent service user involved in developing care plan
  ↓
  Views about factors promoting/hindering these

Creative problem solving

- Extent professionals look for new/ innovative/tailored solutions/treatment for service user
  ↓
  Views about factors promoting/hindering this

Continuous care
- Extent of continuity of care service user/carer has experienced on this occasion
- Extent to which professionals liaise/share information about service user with other professionals/agencies
  ↓
  Views about factors promoting/hindering these

Inter-team working
- Extent professionals communicate effectively with other mental health services if necessary
  ↓
  Views about factors promoting/hindering this

Respect between professionals
- Extent of apparent mutual respect between mental health professionals involved in service user's care
  ↓
  Views about factors promoting/hindering this

Responsiveness to carers
- Extent carer seen as important by mental health professionals involved in service user's care
- Extent professionals offer carer information about services
  ↓
  Views about factors promoting/hindering these

Therapeutic relationships with service users
- Extent relationships with service user are based on openness
- Extent service user is listened to and worked with collaboratively
  ↓
  Views about factors promoting/hindering these

General
- Biggest weakness of/ worst thing about care being received → illustration of this
- Biggest strength of/best thing about care being received → illustration of this

Other
- Any other information about present care

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That's the end. Many thanks for your help.

Appendix 8

Summary of interviewee respondents for stage 3

	Admin	Nurses	Psychiatrists/ speciality doctors	Social workers & support workers	Counsellors/ psychologists	Occupational therapists	Other staff	Service users	Carers	Total
Team 1 (EI)	1	3	2	3	1	1	0	1	1	13
Team 2 (AO)	1	2	0	1	0	1	0	3	0	8
Team 3 (AO)	1	1	0	3	0	0	0	2	2	9
Team 4 (R&R)	0	3	0	2	1	0	0	1	1	8
Team 5 (R&R)	1	2	0	1	0	0	0	1	1	6
Team 6 (CMHT)	0	2	0	1	0	1	0	0	0	4
Team 7 (R&R)	0	3	0	3	0	0	0	0	0	6
Team 8 (EI)	1	3	2	0	0	1	0	1	1	9
Team 9 (R&R/AO)	1	2	2	1	1	1	0	2	1	11
Team 10 (AO)	2	1	0	1	1	1	0	1	2	9
Team 11 (R&R)	1	1	0	2	1	0	0	3	0	8
Team 12 (AO)	0	4	0	2	0	0	0	2	0	8
Team 13 (AO)	0	5	0	5	0	0	0	3	0	13
Team 14 (SM)	1	1	1	1	0	0	1	1	0	6
Team 15 (SM)	1	1	2	1	1	0	0	2	1	9
Team 16 (R&R)	2	1	1	0	1	0	0	6	0	11
Team 17 (OA)	1	2	0	1	0	1	1	1	1	8
Team 18 (CRHT)	1	2	0	2	0	1	0	0	0	6
Team 19 (CMHT)	0	3	0	1	0	0	0	1	1	6

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Appendix 9

MPTW Stage 3 Recording sheet for observation of team meetings

Observer: Trust and team name:

No. of team members: No. of team members present:

Date of meeting: Time meeting began: Time meeting ended:

Type of meeting:

Agenda Y/N: Room layout   Resources used:
(copy attached, if provided)   (plan – please attach):

Research question:

What happens in the team meeting which may impact on service user care?

Recording sheet (NB Only pseudonyms to be used)

Indicator	Comments/illustration
clarity of purpose (explicit / implicit)	
clear communication & decision making	

role inter-dependence	
leadership	
reflexivity	
inter-personal positivity	
Other (specify	

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Appendix 10

Open and axial codes used in Stage 3 interview data analysis

Tree nodes	Sub-Tree nodes
team aims/goals	
continuity of patient care	
creative problem solving	
inter-team and inter-agency working	
	external resources
	inter-agency working
	inter-team working
	referrals

Tree nodes	Sub-Tree nodes
intra-team working	
	caseloads
	consultants
	inter-personal relationships
	inter-professional relationships
	intra-team working (general)
	leadership
	meetings
	mutual learning
	professional roles
	psychological safety
	reflexivity

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organisational context	
	external organisational context
	financial cuts /restructuring /Agenda for Change etc.
	measuring / monitoring
	non-staff resources
	paperwork
	staffing resources and skills mix
	training / development opportunities

service user well-being	
	building positive lives/'recovery'
	care plans/ CPA reviews
	ethics
	honesty and openness
	maintaining professional boundaries
	measuring well-being
	service user centredness /collaboration
	risk
	stigma
	service user involvement
	relationships with service users
carers	
team innovation	
team strength	
team weakness	

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Appendix 11

Abbreviations used in quotations in Chapter 4

Admin	Administrator or Medical Secretary
AOT	Assertive Outreach Team
C	Trust C
Carer	Carer
Clinical TL	Clinical Team Leader
CMHT	Community Mental Health Team (Adults)
Consultant	Consultant Psychiatrist or other Consultant doctor
CPN	Community Psychiatric Nurse or Community Mental Health Nurse
CPsy	Clinical Psychologist
CRHT	Crisis Resolution & Home Treatment Team
E	Trust E
EI	Early Intervention Team
F	Trust F
G	Trust G
J	Trust J
OA	Older Adults Team
OT	Occupational Therapist
R&R	Recovery Team
Registrar	Psychiatric registrar
SM	Substance Misuse Team
Specialist dr.	Specialist staff doctor
SU	Service user
Support	Support Worker
SW	Social Worker
TC	Team Co-ordinator

TL	Team Leader
TM	Team Manager