

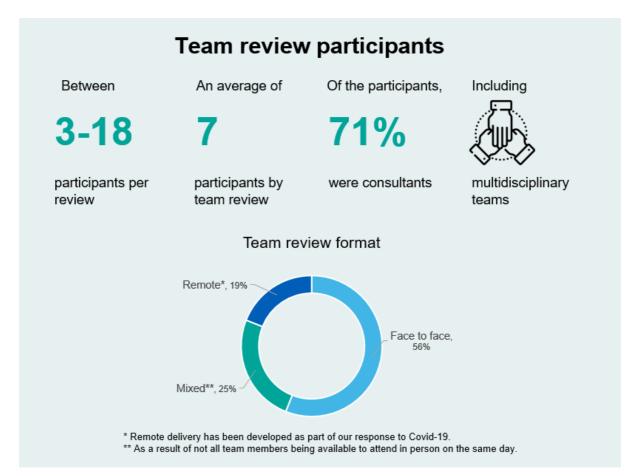
Practitioner Performance Advice Insights Team reviews retrospective

October 2021

NHS Resolution's Practitioner Performance Advice service has developed its team reviews over the last five years. Where concerns relate to how members of a clinical team interact with each other, we can undertake a team review to:

- identify any barriers to resolving the issues which have been highlighted and
- suggest a plan for improving professional relationships within the team.

This publication looks at key themes and data from the reviews completed between November 2016 and March 2021. It is intended to share information about team dysfunction and the adverse consequences that can arise from it, as well as our experience of what helps to enact positive change.



What is a team review?

A team review is intended to support the management of concerns about, or related to, the performance of a team as a result of poor relationships. A team review aims to help an organisation identify barriers to resolving the concerns and to suggest options for improving professional relationships within the team.

The focus of a team review is the behaviour(s) and/or conduct which is adversely impacting on how a team function and conduct themselves. It is distinct from a Royal College Invited Review in that it is not intended to address or pass judgment on clinical performance or technical and/or systemic concerns.

Requests for team reviews can be made by NHS employing and contracting organisations, from both primary and secondary care, as well as private healthcare organisations and health authorities in other jurisdictions.

The current methodology for team reviews is summarised in the annex.

You can find out more about our team reviews service, including watching a short animated presentation and case study, on our <u>website</u>.

Why is team working important?

We recognise the critical importance of personal and environmental factors which can affect behaviour and performance, such as systems and processes as well as fatigue, workload, team relationships and communication – all of which impact on the ability of an individual and team to deliver safe care.

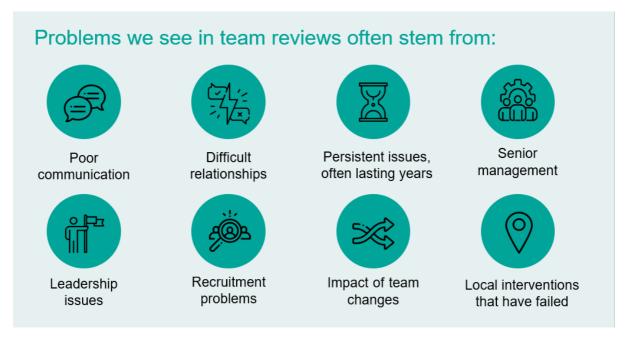
Effective teamwork in clinical teams is key to improving safety. Our own experience of supporting healthcare teams which operate in a range of clinical settings and who find themselves in difficulty, highlights a number of features which commonly lead to team dysfunction:

- complex personality profiles with a small number of individuals who dominate the group
- entrenched professional rivalry between practitioners in the same team which obstructs and limits the scope for healthy challenge within that team
- disruptive and aggressive behaviours which overspill into intimidation and bullying
- circumnavigation of managerial channels and seeking to interfere with decision making
- failure to work collaboratively and recognise the contribution of other professionals
- poor communication and lack of trust, adversely impacting on interpersonal relationships
- excessive complaints against members of the team which are used to personally undermine, rather than strengthen, practice and governance.

Key themes and points of interest

We have identified a number of themes and some case-specific points of interest from our completed team reviews. These are divided into: concerns identified; impact; and options for change. However, it should be noted that that these reviews all arose as a result of circumstances which were specific to the teams concerned.

Team concerns identified



- **Communication:** including lack of clear (or any) communication about the outcome of concerns raised previously; poor communication about team changes; and the absence of a regular, safe, well attended and open forums for team discussion and constructive challenge.
- **Specific poor relationships between team members:** this is often only directly involving some of the team's members (although the indirect impact can spread throughout the team), with identified specific conflicts between certain members of groups of members.
- **Persistent issues:** specific concerns within the team have often lasted for a number of years.
- **General/senior management:** relating to management structures outside of the team in the broader organisation, including perceptions of poor communication and lack of support (including both specific management support and resourcing).
- Leadership in the team: including leadership styles; behaviours (for example, perceived unfairness or bullying, lack of psychological safety) of those in leadership roles; and the perceived ability of those in such roles.
- **Recruitment/appointment to team roles:** including both process and outcome, often relating to clinical lead roles.

- **Impact of team changes:** this includes concerns arising from the management and implementation of changes to team size and remit as well as to changes in physical location and organisation.
- **Local interventions:** have often failed to provide any significant resolution with concerns becoming so entrenched that matters have progressed beyond the point where they can be tackled solely within the organisation.

Impact of poor teamworking

Impact on patient safety and quality of care is a consideration in any discussion of concerns about a team's performance. In only two of the cases were specific clinical concerns flagged explicitly with us as part of the request for the review. However, the non-clinical concerns described in many of these cases had the potential to increase the risk to patient safety, given the adverse consequences of a dysfunctional team.



Some examples of specific impacts identified during the reviews are:

- Team members emotionally exhausted, with some having left and others contemplating leaving.
- Awareness of the tensions within the team having an impact on the willingness of team members to speak out openly about concerns.
- Certain consultants only working with others on a very limited basis, impacting on overall team performance.
- All team members reporting stress and anxiety from the interpersonal relationship concerns within the team.
- In addition to a negative impact on team members, the concerns were also causing problems to the wider community for that specialty and making recruitment and training very difficult.

Options for change

Some of the options for change were very specific to the circumstances of the review in question (for example, the commissioning of a clinical audit or reviewing the operational model for ward rounds). However, there are some others that were identified in a number of cases as being for the commissioning organisation to consider.



The options presented by Practitioner Performance Advice are aimed firmly at supporting the resolution of the concerns identified, and can be incorporated into a management plan to deal with those specific issues. We can, as needed, support the organisation to implement that plan through, for example, facilitated discussions.

If you would like to speak to us about concerns related to team dysfunction or problems with team working, please contact the Practitioner Performance Advice service by phone at **020 7811 2600** or by email at <u>advice@resolution.nhs.uk</u>.

Annex: Overview of team review methodology

- The team review is carried out by two of our Case Advisers, who have extensive experience of dealing with complex cases and how to resolve them.
- The approach provides, at the outset, an opportunity to hear from the organisation commissioning the review what the general impact of the difficulties is felt to be.
- Participants are invited, in advance, to complete an online questionnaire to gather their individual views on the performance of the team.
- The reviewers will then gather information through facilitated discussions with each member of the team (participants).
- From these discussions the reviewers will distil the key issues and form a view of what is happening within the team. The reviewers may decide to provide initial high level feedback to the commissioner immediately following the meetings.
- A report will then be prepared, summarising the original concerns expressed by the commissioner and the reviewers' interpretation of the key issues impacting on the team.
- The report will also set out options for change which provide a pragmatic approach to support the management of the issues.
- The options for change will include those that relate collectively to the team but may also extend into individual plans for some or all of team members, involving differing interventions and/or management action.
- The reviewers will be available to support any subsequent meetings between the commissioner and team to discuss the report and actions arising.

Our *Insights* publications share analysis and research which draw on our in-depth experience providing expert, impartial advice and interventions to healthcare organisations. By sharing these insights, we aim to support the healthcare system to better understand, manage and resolve concerns about doctors, dentists or pharmacists. You can find all past reports <u>here</u>.

If you are interested in hearing more about our research and insights programme, please get in touch with us at <u>Advice.ResearchAndEvaluation@resolution.nhs.uk</u>.

If you'd like to learn more about our work and the services we offer, please visit our dedicated <u>Practitioner Performance Advice webpages</u>. Our Education service offers <u>training courses</u> to provide healthcare organisations with the knowledge and skills to identify and manage performance concerns locally.