Building Resilience in Health and Social Care Teams

Introduction

In the United Kingdom (UK) integrated care underpinned by team work practice and joint working is seen as one model that can be of benefit to service users (Brown *et al*., 2003). Maintaining this user-focused team working in complex care delivery situations is one of the demands made of health and social care (H&SC) organisations who need employees that are resilient, resilience being "the ability to persevere and thrive in the face of exposure to adverse situations" (Rogerson & Ermes, 2008, p.1).

As lessons are learned from public inquiries into poor care standards in the United Kingdom (UK), for example in the Mid-Staffordshire National Health Service (NHS) Foundation Trust (Francis, 2013), the UK industries that report the highest rates of total cases of work-related stress (three year average) are human health and social work (Health & Safety Executive, 2013). Howard (2008) identifies the significance of resilience in protecting employers from the impacts of employee work-related stress. Munro in her report on the current state of UK social work practice acknowledges the presence of stress and occupational burn out in social work and identifies one means of addressing these is the need for organisations to build the resilience of professionals (Munro, 2011). Grant and Kinman (2012) write that resilience is a complex and multi-dimensional construct that is increasingly seen as relevant to those in emotionally challenging and complex occupations and is underexplored in social care work. Subsequently a focus on resilience of staff in teams is an important topic for research in health and social care organisations, with lessons for other health and social care providers globally.

This paper presents the results of a UK study with H&SC managers. Data collected from five focus groups (n = 40) was used to explore resilience and its usefulness in H&SC

teams. The research objectives were to capture the views of team leaders and managers working in integrated health care settings to examine:

1. The place of resilience in the team work setting in H&SC.
2. The making of resilient teams and factors that may influence their performance.
3. How these findings can assist organisations in their workforce development strategy.

Resilience

The development of the idea of 'mental capital' in relation to positive psychology in the workplace includes resilience at its core (Luthans, 2002). Positive organisational behaviour (POB) is the "application of positively oriented human resource strengths and psychological capacities that can be measured, developed, and effectively managed for performance improvement in today's workplace". Relevant psychological capacities are efficacy, optimism and resilience (Luthans, 2002, p.695). The Oxford Encyclopaedic English Dictionary (Pearsall, 1995) defines 'resilient' as relating to a person 'readily recovering from shock' and 'buoyant', and these ideas have been reflected in the literature on psychological resilience. For example, Tugade and Fredrickson (2004) suggest resilience is the ability to bounce back from negative emotional experiences, and flexible adaptation to the changing demands of stressful experiences. Rogerson and Ermes (2008) propose resilience is the ability to persevere and thrive in the face of exposure to adverse situations, whilst Luthar and Cicchetti (2000) suggest it is a dynamic process of positive adaptation within the context of significant adversity and what differentiates resilience from other positive psychological capacities is the opportunity for pro-active learning and growth (Youssef & Luthans, 2007). Resilience is linked strongly to well-being which has a number of different forms and definitions, with personal well-being usually including a self-evaluation of one's life

experience (Warr, 2012). One key difference between resilience and well-being is that well-being is largely set at a moment in time whilst resilience is a more dynamic construct where the maintenance of performance over time is key.

Fisk and Dionisi (2010) note that resilience is a construct which includes a number of psychological behavioural characteristics including self-monitoring, self-efficacy, self-evaluation, the five personality traits and emotional intelligence. Other stable personality traits such as hardiness (Kobasa, 1979; Kobasa *et al.,* 1982) and the promotion of positive self-concepts have been related to positive emotionality (Gupta and Bonanno, 2010) and to resilience (Robinson *et al.,* 2014). The literature on personality traits and resilience is well developed from Block (1961; 1978) onwards. Mancini and Bonanno (2012) acknowledge the significance of Blocks' ego resiliency scale (Block & Block, 1980) in measuring motivational control and resourceful adaptation as relatively enduring aspects of personality in generating research on responses to stress. However Pangallo *et al.* (2014) argue it is the circumstances and environment in which resilience is required that may be important when psychological developmental factors are taken into account, thus causing challenges in determining the likelihood of an individual's resilience.

Further challenges occur when considering workplace settings where resilience has been seen as significant in mitigating against stressful events by the use of behaviours for adaptation (Mallach, 1998). Those individuals who develop mental, physical, and social resources that contribute to their well-being and that foster effective decision making and successful coping (Zwack *et al*.,), can encourage the maintenance of resilience-promoting abilities and are less likely to suffer from the effects of burn out. Burn out being defined as a prolonged response to chronic emotional and interpersonal stressors (Maslach, 1976) and in the workplace, determined by the three dimensions of exhaustion, cynicism and inefficacy (Maslach *et al*., 1993).

There is a considerable literature which explores and measures individual resilience (Block & Kreman, 1996). However despite a research focus on team-based organisation and delivery, research into the resilience of teams has barely begun (West, Patera &Carsten, 2009).

If the core concept embedded in individual resilience is applied to teams, then one definition of team resilience is a team's ability to 'bounce back' and 'maintain' performance under adverse circumstances (West, Patera & Carsten, 2009, p.253). Performance is the team outputs and delivery, and in the case of integrated teams in the health and social care sector, is likely to be linked to service user outcomes.

Integrated Care

Lloyd and Wait (2005, p.7) define integrated care as "care which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision". Integrated care as a form of person-centred team working enables H&SC provision that is flexible, personalised, and seamless. Stein and Reider (2009) write that integrated care is an umbrella term which includes a range of different practice responses in and across organisations that seek to avoid fragmentation but that differ in their scope and values.

Team Work in the Health and Social Care Sector

Recent changes in H&SC systems in the UK demand new ways of working and of educating health and social care professionals, in order to create a workforce able to meet the needs of service users in the future (Department of Health, 2012). Discussing the organisation of state funded service provision in the UK, Wilson and Pirrie (2000) identified a number of

economic, practical and professional factors 'driving' the movement towards integrated team working. These included: changes in working practices requiring members of different professions and occupations to work together; a focus on the end user and the development of concepts of a 'seamless service' and 'joined-up' policy; increased demand from both potential and actual service users; and a desire to ensure that public services are delivered efficiently thus minimising duplication and waste. The latter in particular is aligned with current economic imperatives. One common definition applied to teams within particular organisations and companies is a collection of people working together to achieve a common goal (e.g. Guzzo & Dickson, 1996). West *et al*. (2004) summarise the arguments for team working from their research on health care and innovation. They conclude that teams and the introduction of work team systems are strongly related to a variety of organisational effectiveness measures including reducing errors and improved patient care. Proctor and Burridge (2008) show, in a variety of sectors, that team working per se makes a difference to financial and productivity levels, rather than quality. The Chartered Institute of Personnel and Development (2009) considers that effective teams have: a common sense of purpose; a clear understanding of the team's objectives; resources to achieve objectives; mutual respect among team members, including valuing each member's strengths and respecting their weaknesses; mutual trust; willingness to share knowledge and expertise; willingness to speak openly; a range of skills to deal effectively with team tasks; and a range of personal styles for the various roles needed to carry out team tasks (e.g. see Belbin, 2004). Delarue *et al*. (2008) in reviewing empirical studies linking team working and organisational performance, concluded that team working enhances operational and financial outcomes through attitudinal factors such as job satisfaction, employee involvement, commitment, trust and reduced stress, and their effect on behaviours such as absenteeism, turnover, and extra-role behaviour.

There is some ambiguity about the nature and interpretation of forms of team working

and team structures under Stein and Reider's (2009) integrated care umbrella in H&SC. Drach-Zahavy and Freund (2007a) define team structure as team relationships that determine the allocation of tasks, responsibilities and authority. In UK acute health and primary care settings the term multi-disciplinary is most commonly used. In UK social care, community and children' service settings the term inter-professional is a predominant descriptor.

Multi-Disciplinary Teams

Wilson and Pirrie (2000) argue that the evidence from the literature indicates that 'multi', as in multi-disciplinary, describes activities which: bring more than two groups together; focus on complementary procedures and perspectives; provide opportunities to learn about each other; are motivated by a desire to focus on clients' needs; and develop participants' understanding of their separate but interrelated roles as members of a team. Malin and Morrow (2007, p.449) describe multi-disciplinary team work structure as "where two or more professionals from different disciplines work together or co-exist alongside each other but separately from each other". Leathard (1994, p.6) notes the term is usually used to describe a team of individuals from different professional backgrounds "who share common objectives but who make different but complementary contributions to practice".

Inter-Professional Teams

In contrast, for many employees in community-based services, the term inter-professional is used to describe the structure. Wilson and Pirrie (2000) describe 'inter', as in inter-professional, as more appropriately used when the activity enables members of the team to: develop a new inter-professional perspective which is more than the sum of the individual parts; integrate procedures and perspectives on behalf of clients; learn from and about each other; reflect critically on their own knowledge base; engage in shared reflection on their

joint practice; surrender some aspects of their own professional role; share knowledge; and develop a common understanding. This team work structure is common in community settings and in children's services. Reeves *et al*. (2011) in their scoping review of inter-professional education and collaboration note poor conceptualisation of what is described as inter-professional activity. They define inter-professional team working as involving different health and/or social care professionals who share a team identity and who work closely together in an integrated and interdependent manner to solve problems and deliver services (Reeves *et al*., 2010).

Team Work in Practice

Collaboration in integrated care may involve several health care levels and stakeholders, including organisations, service users, carers and communities as well as professionals (Odegard, 2007). Wilson and Pirrie's distinction between 'multi' and 'inter' to define structure corresponds well with the subsequent analysis made by Hudson (2007) between pessimistic and optimistic models of team working. The pessimistic model includes a distinctiveness of trait, knowledge, power, accountability and culture, in contrast to the optimistic model where team members share a commonality of values, accountability, learning, location, culture and case.

Drach-Zahavy & Freund (2007a) asked practice managers ($n = 73$)to assess three patient-centred primary healthcare teams in relation to team structure along the two dimensions of mechanistic and organic structuring. Drach-Zahavy & Freund (2007a) define working in a mechanistic structure as being controlled and differentiated. Team members' job accomplishment is planned via a centralisation of authority, routines and formalisation of work and by differentiating roles so they are narrow and specialised, according low personal discretion to members. Akin to multidisciplinary team work which is also boundaried in the

integrated care context, mechanistic working can be likened to teamwork practice in Hudsons' (2007) pessimistic model where professionals hold separate distinctive traits and intervention strategies. In organic structures team roles are more broadly defined giving members wide personal discretion, based on knowledge, autonomy and adaptability, and continual adjustment. For integrated team working this has parallels with the inter-professional team model and Hudsons' (2007) optimistic model of practice where cases are shared and roles are more fluid with shared control. In Drach-Zahavy & Freund (2007a) study, such characteristics led participants to see 'the bigger picture' and cooperate with others. Findings from the primary care teams indicated that mechanistic structuring for teams working under quantitative stress (volume of work) was positively associated with team commitment, which in turn fostered team effectiveness, whereas organic structuring for working under qualitative stress (complex work) improved team effectiveness (Drach-Zahavy & Freund, 2007a).

Delarue *et al*. (2008) suggest that employees under stress can cope by routinising their task environments and falling back on familiar modes of operation. However this creates a paradox as Hudson (2007) observes when patient or service-user need becomes more complex and there is a greater urgency to involve a range of professionals. Joint responsibility for cases means there is less room for individual professional contribution and routine or mechanistic task-based care. At the same time in the UK despite positive moves towards integration, several forms of service delivery model currently co-exist as many acute healthcare settings still have a mechanistic structure in place whilst social care, community and children's services frequently hold an organic structure . This can be problematic when building resilience, as workforce training and learning may not prepare workers for this variation in type of structure and team. One example of this being the introduction of personalised care plans in the UK care sector (McCray & Palmer, 2014).

Organisational Strategies to Build Resilience

Workforce development can be defined as encompassing a range of strategies at the systemic, organisational and individual level (Roche *et al.*, 2002). A focus on employee resilience as one construct of POB (Luthans, 2002) has gained in popularity in organisational workforce development solutions. There remains a lack of agreement in the literature on what resilience is and a gap between how resilience operates for individuals and what mechanisms work in transferring this to groups and organisations (Zellars *et al*., 2012). One field of research supports a bottom-up approach in organisations by employing workers with resilient personality traits (Peterson *et al*., 2008) to build psychological capital and assets in the form of knowledge and skills (Masten &Reed, 2002).

Other researchers advocate a top-down approach and suggest organisations can build resilient individuals by focusing on specific training inputs (Youssef & Luthans, 2007) and risk reduction strategies such as stress management, improving communication, addressing group dynamics and poor leadership (Masten & Reed, 2002). Oi Ling Sui *et al*.'s (2012) study of health workers (n = 1,304) in receipt of personal stress management training found that post training, participants had higher reported levels of positive feelings and scored statistically significantly lower on physical/psychological symptoms and burn out, which may impact on resilience for some individuals.

Breen *et al*. (2014) explored the experiences of palliative care workers in oncology services and the impact of complex cases on personal well-being and resilience. Most organisations in the Breen *et al*. study (2014) left self-care to the individual who may or may not develop or focus on these skills. A number of negative factor**s** resulted including a distancing from the service user and family. McCray *et al*. (2014) report on the impact of formal mentorship, defined by Crisp and Cruz (2009, p.525) as a "*focus on the growth and*

accomplishment of an individual, for help and support with professional development, and psychological support" on H&SC managers' resilience and well-being. Intervention resulted in reported changes in practice and a return to positive valuing of their role and service.

Zellars *et al*. (2012) suggest taking into account both research perspectives when seeking possible workforce development strategies. H&SC organisations in the UK have begun to take a dual approach toward building resilience, by operationalising risk reduction strategies (Skills for Care, 2011) and seeking to attain the qualities of a learning organisation. Senge (1990) defines a learning organisation as an ideal form of organisation based on five key areas: systems thinking; personal mastery; mental models; building a shared vision; and team learning. This is in part a response to the demand for changes in organisational culture, and a need to build in learning that has emerged from public inquiries into poor quality service delivery (Munro, 2011). However resources for workforce development are likely to remain constrained in a sector with numerous competing demands.

Whilst theorists define organisational culture from differing perspectives (Davies *et al*., 2000), the UK H&SC organisations interpret culture as something that an organisation has that can be changed. Organisational culture from this position includes attitudes, beliefs and values about how things are done within it (Davies *et al.,* 2000). There is a common and shared way of making sense of how things happen. Organisational learning (Cyert & James, 1963) is an inter-disciplinary area of knowledge which studies models and theories about how an organisation learns and adapts (Kerman *et al*., 2012). Schein (2006) reports that it is the impact of organisational learning and its components, including adaptation to change, continuous learning, wide participation and accountability within a culture of sharing and communication, that are significant in growing a learning organisation with built-in strategies for resilience. Defined as 'Positive Organisational Behaviour (POB) Resiliency' these components are present within a learning organisation regardless of the stability or instability

of the organisation (Luthans &Yousef, 2007). Components of POB resiliency may include individual behaviours such as learning from setbacks and in strategies to increase creativity and flexibility (Luthans & Yousef, 2007). These can be operationalised through the use of individual or team reflection, defined as "the throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them, and to make contextually appropriate changes if they are required." (Taylor, 2000, p.7), plus attention to managing emotional responses. Edmondson (2002) writes that team learning refers to a process of reflection in which past strategies and behaviour are reviewed, leading to development of modified strategies. Team learning requires that learning is shared with other team members (Kayes *et al*., 2005) and involves cognition, emotion and behaviours shared by individuals, as opposed to individual learning which focuses on individual cognition, behaviour and emotion (Kayes *et al*., 2006; Van der Vegt, Bunderson & Stuart, 2005).

Other areas of research in team learning have focused upon the impact of learning on the team – whether it is lasting or temporary and the applicability of learning to the team situation (Wegner, 1995). DeChurch and Mesmer-Magnus (2010), in a meta-analysis using 65 studies, found team cognition to have strong positive relationships to team behavioural process, motivational states and team performance, and that once the former two were controlled team cognition still had a significant effect on team performance. Learning at team level can play a significant part in effectiveness provided learning is relevant to the team. For example as Hirschfeld *et al*. (2006) suggest, teams should participate in workforce training to master what effective teamwork entails in their organization.

A focus on the unwanted effects of team behaviour, using a problem solving model to understand why poor outcomes for service users happen is important in order to change future behaviour, lessen defensiveness and to build cooperation and subsequently learn

from mistakes (Tjosvold, Yu & Hui, 2004),

Equally attention to managing emotional responses such as the development of mindfulness - a "particular way to pay purposeful attention in the moment to experiences" (Kabat Zinn, 2003, p.145) may be effective. Components of mindfulness practice have been developed by Bishop *et al*. (2004) in terms of attitudes and by Shapiro *et al*. (2006) in relation to attention. In terms of practice behaviour mindfulness may enable a less reactive, more objective and reflective response to a situation and the breaking of old habits and patterns of behaviour. Roche *et al.* (2014) report that the mindfulness may be state like and open to development (Brown *et al.,* 2007). Effectively used mindfulness practice may enable employee stress and anxiety reduction (Shapiro *et al.,* 2005) in difficult situations (Weinstein & Ryan, 2011). Formal workforce mechanisms for facilitating reflection and mindfulness may include the use of mentorship and action learning (Revans, 1982), a learning tool where individuals and teams work in a set on real life workplace issues to resolve problems. The interactions and reflections of members of the learning set are key parts of the process.

The Need for Research on Resilience and Teams in Organisations

Organisations facing external pressures, additional targets and complex healthcare work situations (Jacobs *et al*., 2014) may instil stress-creating situations for their employees (Wiedow *et al*., 2013**)**. This may manifest itself as poor organisational communication and information (Gladstein & Reilly, 1985) and is often set within a demand to deliver services with fewer resources. Employee stress may be triggered by additional role demand and characterised by emotional exhaustion (Maslach *et al*., 1993), negativity (CIPD, 2006) and a de-personalisation of service users (Thomas & Rose, 2009). If employees are in team settings then likely resulting behaviours may include an individual focusing inwards (Driskell &Sallas, 1991), with less attention to team cohesion and its goals, impacting on team unity

and team performance (Johnson &Johnson, 2005). Ultimately this may lead to poor team satisfaction and poor team processes, where team processes are interactions such as communication, and conflict that occurs amongst team members and others (Cohen &Bailey, 1997). West *et al*. (2009) note this inward-looking behaviour may lead to miscommunication and potentially impact on team resilience and performance.

The question of how to maintain and sustain resilient team performance via effective workforce development strategies remains under-researched in the literature (West *et al*. 2009, p.254).

The role of POB components and team outcomes has been tested by West *et al*. (2009, p.254). Their study on college students found that out of three component team POBs, of efficacy, optimism and resiliency in team settings only optimism was an important factor at their start up. Furthermore in terms of some team outcomes such as cohesion, co-operation, communication, conflict and team satisfaction, team resiliency and efficacy was a factor but not until the study was in a later stage and relationships had started to develop. West *et al*. reported that the extent to which POB components impact on team processes and outcomes may be related to team interactions. This may be important West *et al*. explain because when things are difficult, those teams that can rebound after adversity and maintain relationships with other teams, rather than looking inwards, will keep communication channels open. West *et al*. report that the time teams have worked together could impact on further study findings. They conclude that the impact of the POB resiliency could be more significant in other real world settings where the team is more important, recommending more research on teams with set members in organisations and those that are more fluid in membership.

Methodology

A qualitative research methodology was utilised to gain in-depth understanding of resilience

in team work in H&SC, through learning about participants' experiences (Moriarty, 2010). Using a general inductive approach (Silverman, 2011) enabled the research team with different subject discipline backgrounds to work within an agreed framework. This was an important decision (Backett-Milburn *et al*., 1999) because of the possible impact of different methodological preferences on the research team approach to data and its interpretation and how it could influence interaction with participants.

The Sample

Participants who were selected for the five focus group interviews had to meet the following criteria. They were required to be currently employed in leadership roles as team managers and able to discuss and reflect upon resilience in team members in organisations in H&SC. In this purposive sample all had to be working in inter-professional and/or multi-disciplinary teams in H&SC

Table 1

Characteristics of Study Participants

Characteristic	Frequency (*n = 40*)
Gender	
Female	25
Male	15
Ethnicity	
White	38
Black	2

Age	
30-40	30
40-50	9
50-60	1
Role	
Team Manager Health	12
Team Manager Social Work and Care	28

Macnaghten and Myers (2004) write that ideally focus group members should have shared the same direct experience. All were working as team managers in the integrated care context in the South of England and had direct experience of the transformation of services created by the person-centred policy agenda. In each of the five groups there were five women and three men. The groups were facilitated by the lead author as moderator. Each focus group lasted two hours and data was recorded and transcribed by a research assistant.

All participants were undertaking a postgraduate programme in leadership at a university in the UK at the time. As the group members were known to each other as fellow students, but were not with colleagues from their organisational work setting, this reduced the potential for discomfort caused by power and status differences (Morgan, 1993).

The aims of the focus group activity were to:

(1) Seek the views of leaders in H&SC on resilience in integrated care teams.

(2) Identify factors that may influence team resilience in integrated care teams.

(3) Contribute to organisational workforce development strategy to build resilient teams.

Ethical Issues

Before commencing the study, approval from the university ethics committee was obtained. Prior to any involvement, participants were forwarded an information sheet and consent form for signature. A short briefing session was held to answer any questions about involvement and what was expected. Agreement to participate in the form of written consent was gained prior to the start of each group interview from all participants.

The Procedure

A focus group procedure was used. Lindsay and Hubley (2006) write that in contrast to other group structures the aim of a focus group is not to reach a consensus on a topic but to capture a range of perceptions. We also shared with Lindsay and Hubley (ibid) an exploratory position on the topic and were aware we could be presented with uncertainty and ambiguity around the topic as people shared their initial responses and perceptions. Participants in each focus group were asked the same three questions. These were:

(1) What does the term resilience mean to you?

(2) Can you describe the qualities of resilience required for effective team work?

(3) What has worked for you in terms of strategy to build team resilience?

Data Analysis

The data was analysed using a thematic analysis procedure. Thematic analysis is defined by Braun and Clarke as a method of identifying, analysing and reporting patterns in qualitative data (Braun & Clarke, 2006). Each focus group transcript was read carefully, organised, analysed and coded separately, initially by the lead author and then checked by the research assistant. Transcripts were scrutinised and allocated codes independently by the second

author to avoid bias, and then revisited (Braun & Clarke, 2006). Coding has three purposes: noticing relevant phenomena, collecting examples of that phenomena, and analysing that phenomena to find commonalities, differences and patterns (Seidal & Kelle, 1995). Smith, Flowers and Larkin (2009) advocate detailed consideration of each line of transcript to enable the researcher to see beyond what they are anticipating and explore different possible meanings which results in a more interpretative rather than descriptive level of analysis (Collins & McCray, 2012).

Codes were then further revisited and categorised under distinct overarching themes. Themes were determined because they "captured something important in relation to the research questions" (Braun & Clarke, 2006, p.77). The overarching themes generated were Sustaining Effort, Team Learning and Team Work Approaches.

Sub-themes are illustrated in Table 2 below.

Table 2

Sub Themes in data analysis

Sustaining Effort (SE)	**Team Learning (TL)**	**Team Work Approaches (TWA)**
Stamina (S)		
	Team Culture (TC)	
	Team Reflection (TR)	
Resourcefulness (Rs)	Team Processes (TP)	Action (Ac)
Mindfulness (M)	Team Education (TE)	Modelling of Behaviour (MB)
	Learning from Individual	Interdependency (I)
	Experience (LIE)	Type (T)
	Learning From Team	

Experience (LFTE)

Team Feedback (TF)

Coding and descriptors for each overarching theme and sub-themes follow below:

Table 3

Overarching Themes and Sub-Themes: Coding Descriptors

Overarching Theme Sustaining Effort (SE)	**Data which indicates a resolve to strive to perform in difficult situations**
Sub-Themes	**Descriptor**
S Stamina	Data which demonstrates a strength of will to continue working in a situation
Rs Resourcefulness	Data which describes capacity to find a creative way forward
M Mindfulness	Data related to self-attention to the situation and the resulting feelings

Overarching Theme Team Learning (TL)	**Data which indicates learning about how the team and team members work together**
Sub-Themes	**Descriptor**
TC Team Culture	Data that indicates how team members relate, work and behave together
TP Team Processes	Data describing how team members

	communicate with each other
TE Team Education	Data related to team involvement in education about their practice
LIE Learning from Individual Experience	Data which represents an example of individual learning in practice used by all the team
LFTE Learning From Team Experience	Data that is focused on team learning in a practice setting
TFB Team Feedback	Data that includes external feedback to the team that helps team learning
TR Team Reflection	Data that includes team review and processing of a team experience

Overarching Theme Team Work Approaches (TWA)	**Data which indicates Team work activity to enable effective interaction for performance**
Sub Themes	**Descriptor**
Ac Action	Data related to activity to maintain team performance
MB Modelling of Behaviour	Data which describes the demonstration of behaviour for effective performance
I Interdependency	Data which demonstrates the reliance of team members on other teams and team members' perspectives and intervention

T Type	Data which indicates the significance of the type of team in health and social care and its impact on performance outcomes

Results

In response to the question "What does resilience mean to you?" one focus group member defined resilience as:

"*In some ways when you think about resilience you think of examples where people have shown strength in one way or another and I think it is much more subtle than that really. It's difficult to articulate what it is about but it is something to do with actually understanding what is happening around you, knowing when an intervention is going to comparable knowing when it's not and knowing when to play the game really of engagement. Resilience is much more subtle really for us, our lives aren't in danger but we are experiencing stressful work situations which require a subtle kind of way of managing them which enables you to survive really."* (FG3m5).

Sustaining Effort

Under this theme the need for stamina (S) was needed. One participant stated: *"To be flexible and able to adapt to change. An inner strength, a coping capability which can be used and translated into many situations."* (FG1m3).

Resourcefulness (Rs) was required to see the positive in a difficult care setting:

"A capacity to find ways through things. Being able to see when you might be in conflict with somebody or somebody has a different view, perspective or value base and it is about trying to find the common ground and building on the common ground rather than engaging in all those things you'd probably like to engage in which are about reactions to things but somehow managing to keep that back and frame things positively." (FG1m4).

Holding personal resources for resilience in the form of mindfulness (M) strategies was verbalised:

"*I think it is very much linked to emotional intelligence really, when to intervene I think that can be a part of resilience. I compare it sometimes to choosing my battles because I think that if you don't you severely test your resilience by battling on all fronts all the time which is challenging. It is very subtle, being innovative; look at common points of interest. I think it's about looking after yourself really isn't it as well really if you are going to do the best job. So to stay resilient you need to know when to pull back and if you don't have that… and I think that you learn some of that, it comes with life experience actually."* (FG2m4).

Especially within the transformation of services:

"The uncertainty now there is no more 'this is your job and you will keep it for life', all this reapplying for jobs and things is taking a huge toll on people's resilience." (FG3m1).

When participants were asked to describe the qualities of resilience for effective team work, the helpfulness of team settings after complex care situations was noted:

"*It is difficult without help because I think all that learning experience can again build up the team resilience and can help in another situation and also be able to accept that you did*

all you could, not beating yourself up too much and thinking those people have their own problems and needs and unfortunately this is as much as I can do." (FG3m1).

Resourcefulness (Rs) was viewed as important for effectiveness as it was seen as the capacity to:

"*Share reasons why this needs to happen, what are we doing and why this is done this way so people have a roadmap of what they should do so it is not in this sort of double bind situation where people don't know what to do or how to do it, there is a way forward."* (FG3m4).

Team effectiveness may be influenced by team learning which was a key factor in how participants felt resilience could be built and established when asked "What has worked for you in terms of strategy to build team work resilience?".

Team Learning

Within this theme, the culture of the team (TC) was significant for participants:

"There are two things really I would say, one is about creating a culture where you don't expect people to make mistakes but when they do they know they won't be vilified for mistakes but actually it is part of learning." (FG2m5).

"It was the culture we lived in - it actually meant that the culture became a very supportive, engaging, maverick culture." (FG2m4).

Learning about the team and its processes (TP) was valued:

"But also the team had a really good, we had some really good away days with an external facilitator and she said she'd never had a team that were so... I don't know... we did

challenge each other but we really bounced off each other as well, and we had a lot of fun." (FG4m2)**.**

One participant noted *"We may discuss things that have gone well, and maybe not so well and therefore another team leader may say, 'well I could use that.' We discuss things we may want to do to improve the whole team work."* (FG4m1).

A participant observed:

"Numbers change that we are dealing with. So we learn from our experience and then we think, 'ah well can we have a meeting and discuss how we do this differently'." (FG2m6).

The value of the team as an enabler of team education (TE) is highlighted:

"The team helped everyone with reflective learning and that if something had gone wrong you felt you were innocent until proven guilty and not the other way round as is so often the case." (FG1m8).

Learning from Individual Experience (LIE) was also seen as invaluable for the team:

"The team can help them to try out ways of doing things to get them to think about what their intervention was and is there another way of trying it and perhaps next time you have that meeting with that difficult group you can try it out and eventually you will find the right button or the right way." (FG1m7).

With learning from team experience (LFTE) paramount:

"So if there had been an incident we would look at how that had happened, how we're going to work as a team to prevent that happening again, will we change the guidelines, will we do that? So that sort of thing would happen." (FG1m7*).*

Feedback given to the team (TF) was also used for learning when work is tough:

"You can learn how to observe what happens, all the stuff around who are the people that talk the most, sit beside each other, if you can get a sense of some of that. I think those are things that people can learn." (FG4m5).

Whilst opportunity for reflection (TR) is helpful to build resilience:

"*In a reflective learning capacity I was thinking about you could build on people's resilience.*" (FG3m6).

"The important thing is how you coped with what happened to you. But that is the same in life in general, how are you now? It doesn't matter what you have gone through in life, reflecting on experiences can help you, how have you categorised that, dealt with it and moved on and learnt from it." (FG4m7).

"It's about providing space to talk and take on other people's points of view and coming to a decision." (FG1m5).

Team Work Approaches

Equally team work approaches were significant when the participants were asked "What has worked for you in terms of strategy to build team work resilience?"

Focus group participants offered their experiences of different approaches (TWA) working in teams:

"We'll have sort of board meetings looking at projects and things like that together, if we're looking at financial recovery or working towards personalisation, about individualised

budgets and things like that, so we work together for that to try and move forward." (FG2m 8).

Part of this working as a team and the action (Ac) needed did require resilience. One participant noted:

"We deal with the agencies, structure is constantly changing, especially with us being a national resource, and dealing with all the local authorities in the country, we have to be on the top of our game at all times, we can't slip." (FG3m4).

This pressure was managed through team work with an acknowledgement of interdependency (I) in terms of tasks and outcomes:

"It's about providing space to talk and take on other people's points of view and come to a decision that is acceptable to the whole group, it might not be what one part of it wanted but ultimately if you are working in a multi-disciplinary team there is a common aim, for example child protection involves a lot of different agencies you have got to be able to listen to all those views and respect the opinions before you come to a decision." (FG3m5).

A recognition of the importance of role modelling (MB) to others in the team was underlined:

"I would say that part of it is to do with modelling, by modelling behaviours you present yourselves to your peers showing how you handle things. I would say that mentorship and people moving alongside to allow a smooth exchange." (FG1m2).

For these focus group members, the type of team (T) the participants were members or leaders of was a significant factor for effective performance when the situation was difficult. The challenge faced was noted:

"We had a meeting recently, we had 17 professionals in a meeting about one child and it was just bloody madness. Honestly all these people 'I know better, I know better' oh shut up we are dealing with the child. It was really interesting to see the different perspectives of this same child from different professionals." (FG2m6).

Whilst

"Unless the team is properly established and at the multi-disciplinary teams you don't often have the same people attending do you. So don't see how they can actually build what you need and be functional as a body when things are tough if you know what I mean." (FG2m2).

and:

"The people who are in the multi-disciplinary team, most of the people in the team that are in their respective professions but performing as a whole, have done that for a while. So they've come into the team knowing what they should be doing. So their experience and qualifications are already there, however sometimes we do make mistakes, we don't quite get the right approach." (FG3m7).

However such investment in the team (T) is not without cost as one participant stresses:

"But it is hard you know, engaging all the different disciplines and making it worth their while coming along and contributing to it and I think if you had this sort of hierarchal structure (multi-disciplinary) it just wouldn't work." (FG3m5).

*"Yes, it's the perceived structure within the team I think. Our job reflects the making up of the team and the people in it. You can have one person in there could be the kind of the fly in the ointment that upse*ts." (FG3m7).

There was a general feeling that change can take place and resilience be built:

"*If it is an inter-professional team of people working reasonably autonomously… I think people often learn best through their own learning if that makes sense and they need to have opportunities to develop more links and collaborative work."* (FG3m7).

Whilst team learning was further noted (TL):

"*One way is about creating an inter-professional team where you don't expect people to make mistakes but when they do they know they won't be vilified for mistakes but actually it is part of learning."* (FG1m5).

"Shared responsibilities help a lot, yeah. In the inter-professional work it is pretty much sharing the load, and we do that in the good times as well." (FG3m6).

Discussion

Individual Resilience

Individual resilience was seen as important for performance in the H&SC workplace. To achieve it care and attention to the self were reported as paramount (Themes S, Rs and M). This aligns with other research from Roche *et al.* (2014), Brown *et al.*, (2007), Shapiro *et al.*, (2005) and Weinstein and Ryan, (2011) reported earlier in the literature review. Strategies identified to alleviate burn out and increase well-being and performance in this study included active listening to difficult case observations, supervision and individual debriefing. The emphasis on mindfulness as a tool to build resilience (Theme M) is supported in the non H&SC literature related to team cognition, including knowledge sharing.

Factors Affecting Performance

A new finding is that participants valued the team as a very important vehicle for building and sustaining resilience when dealing with complex H&SC situations (Theme TF). This can be explained in the way that participants viewed their team as a place of learning to share team challenges, review action and evaluate outcomes (Themes TE, LFTE, LIE, TR). The reported experience of participants here describe their team as a helpful place to work

together to find solutions, model positive behaviours and seek ways forward in difficulty making them more effective in a future scenario. Only one participant across the sample mentioned being held back by poorly performing members in relation to performance and overwhelmingly participants perceived their team as the positive vehicle for their performance within the organisation and through times of difficulty (Themes TC, TP).

Team Resilience

Participants discussed their team and its relationship with other teams (Theme I) and what could be learned and changed from such reflections to build team resilience (Themes LFTE, TR). This is a multi-faceted issue, and learning by reflection and reviewing experience and interaction either as a team or with an external facilitator was viewed as a critical factor in team effectiveness and future performance improvement.

The participants reported their perceptions of the strength of team relationships (Themes TC, TP). The impact that these had on team learning (Theme MB) and in building resilience for adversity was an important and new finding of note in this study, when the difference in team type, structure and working practices of multi-disciplinary and inter-professional teams is considered (Theme T).

In the literature review and the study data presented here (Theme T) a mechanistic structure is more evident in the working practices of multi-disciplinary teams and an organic structure more evident in inter-professional teams. Hence in the multi-disciplinary team stress should have a smaller impact on team performance if there is less complexity due to change. Professionals can use more routinely familiar procedures, may be interchangeable and fall back on pre-existing professional training. This type of strategy would clearly work best in multi-disciplinary teams. For this reason one adaptation to stressful conditions could involve restructuring inter-professional teams to be more multi-disciplinary. Doing so would be contradictory, since inter-professional teams would appear to be effective in complex integrated care precisely because they are more integrated with better team work processes. From the findings of this research study, given that the two most common types of team structure used in H&SC are multi-disciplinary and inter-professional, to build resilient multi-disciplinary teams, where members tend to work as individuals within professional boundaries, a team should be made up of resilient individuals (McCray & Chmiel, 2012). Focusing on individual learning for resilience may be one key to sustaining effective multi-disciplinary team working. Typically this learning would involve individuals reflecting on practice, individual development of knowledge and management of emotion such as in mindfulness training. To build resilient inter-professional teams, where members are more closely integrated, focusing upon team learning for resilience may be a critical factor. This

team learning may include team reflection in the form of incident debriefing, evaluating team relationships, action and effectiveness within performance cycles and reported outcomes for service users.

Issues for Organisational Workforce Development Strategy

These findings have a number of implications for organisational workforce developers. We recommend specifically that H&SC organisations in the integrated care context make a clearer and more transparent distinction between the two most prevalent team types and structures of multi-disciplinary and inter-professional teams. Second, organisations should plan more targeted multi-level workforce development incorporating bottom-up and top-down interventions for individual and team learning for resiliency within these distinct team structures. We suggest that organisations should facilitate learning that would involve individuals reflecting specifically on how they practice in multi-disciplinary teams via mentorship or individual development of knowledge and management of emotion such as in mindfulness training. Organisations should consider investing resources in the design and delivery of such solutions, for example using an accredited skills framework or action learning set for formal reflections on practice (McCray & Palmer, 2014), or mentorship sessions can provide a vantage point and foundation for tracking and evidencing learning (McCray *et al.,* 2014). To build resilient inter-professional teams establishing or building on pre-existing team learning should be a priority for organisations. This may include planned team reflection sessions focusing on relationships, roles and performance, team reviews, difficult case and critical incident debriefing, and evaluating team relationships and processes over time and/or an intervention. Finally, we recommend that H&SC organisations evaluate workforce development inputs for effectiveness within measured team performance cycles and reported outcomes for service users. In doing so organisations may gain further data on the impact of workforce development intervention and how advantages such as improved team performance in problematic care situations can be gained.

Conclusions, Limitations and Future Research

This paper has reviewed key concepts and established theories to explore and identify the characteristics of team resilience. Concurring with other more general research into resilience it adds new insights and advances the understanding of resilience in teamwork in H&SC which may be applicable to other H&SC employees working in an integrated care team context. The primary research study undertaken and reported offers new evidence to determine what factors contribute to resilient teams given the two main differences in team type in integrated care. From this team type distinction, strategies to support workforce

development and performance outcomes required from team professionals in H&SC have been identified.

Limitations of the present study are that data captured is self-reported perceptions of H&SC managers. Participant responses in the focus group situation may have been those expected rather than those actually modelled in the realities of team work practice (Tanggaard, 2008). Further, in the sample all participants were engaged in a Higher Education programme and it is possible participants may have been more engaged with their practice and thinking more critically about the research questions than those not currently undertaking postgraduate study (Ng *et al*., 2014). Nor were the researchers able to observe the participants in team work practice over time or during critical care delivery incidents. Individual perceptions of different occupational or professional roles within teams were not explored which could offer a further dimension to the study of resilience in teams.

Further research is required to add to our early findings. Evidence should be collected from real world H&SC team work settings and take into account the two different team types of multi-disciplinary and inter-professional. A longitudinal study would enable researchers to explore the impact of potentially negative inputs on performance, for example volume of work, resource cuts or complex care delivery in emergency situations in H&SC, and those identified as positive such as workforce development interventions. Further, other sources of data beyond self-reporting should be included, for example organisational records of team performance such as attendance at work, sickness levels, retention, along with other indicators in the form of outcomes for service users such as discharge numbers, maintenance of care support, stability of family setting and reduction in hospital admission.

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