

**SPECIAL REPORT**

# Co-creating a program for teams to maintain and reflect on their flexibility

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**Summary**

To prevent rigidity within teams in health care and to support teams in detecting early warning signs of decreasing flexibility, a program has been co-created in collaboration with mental healthcare teams. This program is intended to systematically monitor team behavior, and by doing so to facilitate team intervention. We aim to lay foundations for the further development of methods that can help teams to recognize and respond to processes going on under the surface.

This paper introduces the program to the reader; and describes its premises and the co-creation process, leading to a program of nine steps. Then, it describes the application of the program within a team, what a team needs to use the program, and whether the nine steps are sufficient. This pilot shows that the program is a helpful framework within which teams can talk about rigidity, define indicators of their flexibility, and think about appropriate actions and interventions for maintaining or restoring their flexibility. Team ownership and the customizability of the program are important attributes. The program appears to provide a useful framework that helps a team to observe and discuss processes. Team members become aware of the indicators of their team and make their goals explicit.

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**KEYWORDS**

flexibility, team development, team management, teams

## 1 | INTRODUCTION

“How do you prevent this successful team from becoming rigid in the future?” This question was asked by one of the authors during a conversation with the manager of a high intensive care unit (HIC) in a Dutch mental health hospital. As a pioneer in a new way of organizing and caring for people with a severe mental crisis, this team was very successful. Their ward, their philosophy, professional attitude, and skills were mentioned in the national media. The results were inspiring: they managed to reduce isolation and the use of forced care to a minimum. Many visitors came to learn from them and this ward became an example for other hospitals. Why then this question about rigidity in the future?

The answer to that question is that in a team working shoulder to shoulder and watching each other's backs, there is a big risk of developing rigidity. Working in an HIC, which is an intensive and sometimes even threatening environment, solidarity and loyalty are important. Too much solidarity and loyalty easily leads to decreasing criticism and diversity.<sup>1,2</sup> Teams have to balance between cohesion and diversity, flexibility and consistency, and individual and group interests. Some teams tend to manifest rigidity, for example, in the externalization of responsibility, identification with a specific position, fixation on incidents, and other phenomena.<sup>3</sup> To remain flexible, teams have to prevent rigidity, groupthink, and decrease vitality in the long-term. This flexibility is important for the group and work climate on the ward, the balance between control and trust, and the quality of care.<sup>4-6</sup> But flexibility is a complex and abstract concept for most of the team members, and it is difficult to perceive and counter slowly developing rigidity in teams, especially from within.

With this in mind, a program was developed for teams to maintain and reflect on their flexibility.

This program consists of a set of meetings, procedures, and questionnaires, and is designed to systematically monitor team behavior and by doing so to facilitate team intervention. With this program, we aim to help teams to talk about rigidity, define indicators of their changes in flexibility, and think about appropriate actions and interventions for maintaining or restoring their flexibility in a self-directing manner.

In this article, we describe how the program was co-created and adjusted, first with one mental health care team and later in a pilot with nine teams. We explain the premises of the program and then describe how this leads to nine steps by which the program is operationalized. Finally, we report on the first experiences with the program in the pilot within nine (mental) healthcare teams. On the basis of this first pilot, we aim to find input for further development and refinement of the program.

## 2 | PREMISES OF THE PROGRAM

As a first step in the development of the program, the basic premises were formulated. This section introduces these premises. They formed the foundation for the first design of the program that was proposed to a selected team.

The first premise is ownership. A team takes responsibility for molding the process to its own needs and expectations on the assumption that this form of self-management and autonomy increases the motivation of team members to use the program, and thus makes the use of the program more effective.<sup>7-9</sup> This is translated into customizability of the program. The team members formulate their own indicators, and they customize the frequency of the questionnaire and the meetings based on their team goals and needs.

The second premise is early recognition. This consists of the quick identification of early warning signals and a rapid response to prevent a problem escalating. This is based on studies on crisis management and team development which emphasize the importance of the early recognition of unwanted developments<sup>2,10,11</sup> and early warning

signs of conflict.<sup>12-14</sup> In the program, this is operationalized by the team in a meeting at which they formulate indicators of the early warning signs of rigidity. The indicators are the basis of the recurring questionnaire with which the team monitors itself.

The third premise is the division of the concept of flexibility into four “perspectives.” It concerns the complexity and abstraction of the concept and the difficulty for team members to perceive and counteract processes going on under the surface. These four perspectives are formulated in the program as reference points for exploring different aspects and indicators of flexibility in a team. The literature makes reference to many categories of behavior and dimensions of teamwork.<sup>15,16</sup> In this program, the researchers and the first team decided to define learning behavior, cooperation, decision-making behavior, and vitality as perspectives or a framework for assessing flexibility.

The first perspective is team learning behavior. Learning is seen as a key antecedent of flexibility. Single, double loop, and deuterio-learning make quick adaptation and implementation of knowledge possible.<sup>17,18</sup> Scholars argue that organizational learning leads to enhancement of the capability to recognize opportunities.<sup>19</sup> Team learning in organizations is defined as “an ongoing process of reflection and action” characterized by asking questions, seeking feedback, experimenting, reflecting on results, and discussing errors or unexpected outcomes of actions.<sup>20</sup>

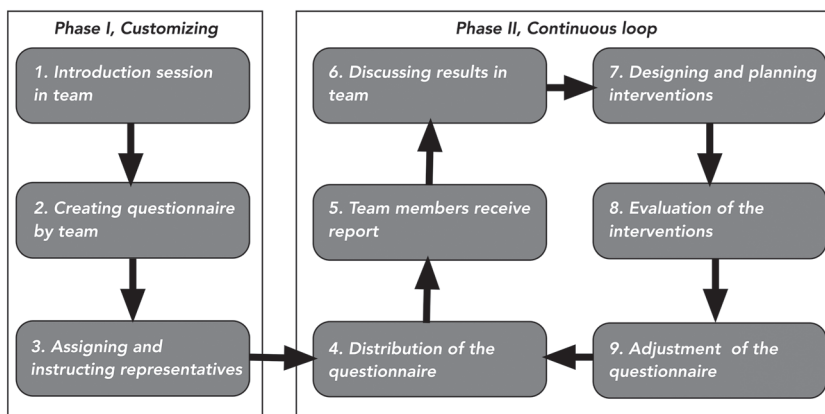
The second perspective is cooperation. Cooperation is defined in the literature as: “the willful contribution of personal efforts to the completion of interdependent jobs.”<sup>21</sup> It is seen as the opposite of conflict.<sup>22</sup> Cooperation is a central concept within teams and it is seen as imperative in defining team flexibility, since cooperation is the most important variable in explaining team performance.<sup>23</sup> Cooperation leads to flexibility via the following two processes. Firstly, by enabling an organization to adapt quickly to changes in the environment, and, secondly, by fostering flexibility in services or production, which leads to adaptive capacity to adjust to changes in the environment.<sup>24</sup>

Decision-making behavior is the third perspective. Decision-making behavior is an important perspective in relation to team flexibility. This is because of the fact that decision-making behavior and processes are linked to effective (self-managed) teams.<sup>25</sup> The importance of decision-making behavior to achieving team flexibility is explained by the potentially increased decision-making quality of groups versus individuals. This is because of the fact that teams are able to take more information into account and (thus) make better-founded decisions.<sup>26</sup> This is an advantage in complex environments and situations where changes are frequent, where individuals will inevitably suffer from information overload.<sup>27</sup>

The final perspective is vitality. Vitality refers to the degree to which a team and its members experience positivity and support from the environment in which they operate.<sup>28</sup> Key concepts related to vitality are learning and openness.<sup>29</sup> Vitality leads to increased engagement of individuals and teams, and in turn to an increase in perceived opportunities to learn and to better performance in difficult situations.<sup>29</sup> More specifically, vitality provides teams and individuals with the energy to correctly respond to novel situations and uncertainty, enhancing flexibility<sup>29</sup> and resilience with “the positive psychological capacity to rebound, to ‘bounce back’ from adversity, uncertainty, conflict, failure ....”<sup>30</sup> These perspectives are not all inclusive, but can be seen as factors for grasping the concept of flexibility.<sup>18,24,27</sup>

The four perspectives render the abstract concept flexibility more concrete and make it more manageable for the teams.

These three premises, together, establish a process of creating, doing, learning, and being adaptive. The first author designed a first concept of the program on the basis of these premises and presented this to the high intensive care team of a mental health institution, the team mentioned in Section 1. This team was looking for a way to work on their team dynamics, and the team members, supported by their manager, were willing to experiment. A workgroup of team members constructed, discussed, refined, and adjusted the steps of the program in two work sessions. This co-creation process resulted in a program of nine steps that will be explained in the following section.



**FIGURE 1** The nine steps of the program

### 3 | THE PROGRAM IN NINE STEPS

In this paragraph, we describe how the program is structured in nine steps (Figure 1), the key issues in every step, and roles of the different stakeholders. The program has two phases. First the customizing phase in which the program is set up and customized. Second, the continuous loop consisting of the process of monitoring, discussion, and interventions. These phases and the underlying steps are described below.

#### Phase I Steps 1-3: Customizing the program per team

During the first three steps, the teams define and customize their own team-exclusive monitor. This takes one session with the team.

##### 1 Introduction session of the program

The program is guided by a “facilitator.” His role is to inform the team, support the team in directing and structuring the process, lead the team sessions, prepare the questionnaire, write the reports, and support the team representatives. In a 30-minute presentation, the facilitator explains the goals, the program, and potential value and outcomes using a PowerPoint presentation. The team members decide whether they want to use the program or not.

##### 2 Start-up meeting: creating the questionnaire

In a “world café-like” session,<sup>31</sup> the team collects indicators of flexibility for the four perspectives: learning behavior, cooperation, decision-making, and vitality. The team members first collect “indicators”; the behaviors and feelings regarding team dynamics that they can observe, and the behaviors relating to the four perspectives. Subsequently, on the basis of the collection of indicators, the team formulates 24 statements as items for their questionnaire (compiled in Google Forms). The respondents’ score anonymously on a 7-point scale from *totally disagree* to *fully agree* on each statement.

##### 3 Assigning and instructing representatives

The team chooses one or more representatives. The team representatives are the “linking pins” between team and facilitator. They distribute the questionnaire, send reminders and reports to all the team members, stimulate colleagues to submit their questionnaires, and they are the initiators and organizers of team activities and interventions. In a 2 hour meeting, the representatives are instructed by the facilitator. The steps are explained, and the roles and tasks are briefly discussed.

## Phase II Steps 4-9: the continuous loop

Steps 4 to 9 form a continuous loop, a 4- to 8-week cycle depending on the preference of the team. This loop is the monitoring part of the program, and it supports the team in recognizing early warning signs and intervening when necessary. The steps are:

- 4 The questionnaire is distributed monthly using Google Forms.
- 5 One week after the monthly deadline, the team members receive a report on the results.

This report shows:

- the response rate,
  - a radar chart of the current results,
  - a radar chart of the results of the previous period,
  - the highest scores,
  - the lowest scores,
  - decreasing and increasing scores,
  - an overview of all the scores per period
  - an overview of all the scores per question, and
  - the answers to the open questions.
- 6 The results are presented and discussed in team meetings.
  - 7 The representatives initiate interventions in team sessions held for analysing the results, coaching, and designing interventions.
  - 8 An evaluation of the interventions in the team. This can lead to the adjustment of the interventions or new interventions as a contribution to continuous improvement.
  - 9 Adjustment of the questionnaire. After 1 or 2 months, a session will be organized to analyse the first results. One of the key issues is to evaluate the items and to adjust the questionnaire when needed.

In summary, the program provides teams with a set of procedures, forms, and techniques that, supported by a facilitator, can be used to monitor their flexibility in a structured and self-directing manner. It starts with phase 1 in which the team members, on the basis of their team goals, define their team questionnaire covering their indicators of flexibility. Monitoring these indicators in phase II by repeated use of the questionnaire supports the recognition of early signs of rigidity.<sup>2,10,11</sup> The reports are input for team meetings in which the members reflect on the insights and feedback.

## 4 | THE PILOT: EXPERIENCES WITH THE PROGRAM IN PRACTICE

Subsequently, a pilot was conducted with nine mental health care teams in order to gather experiences on the use of the program for guiding the further development of the program. This section describes the experiences of the teams. We wanted to explore whether the nine steps offer sufficient support for teams to work independently with the program, and how much support is needed.

The first team and their manager were co-initiators, starting this project together with the researchers. In the three other teams, the program was introduced by the team manager as part of their HIC learning program, and the

other five teams volunteered after a request from the researchers. The teams were introduced and guided according to the nine steps program. In team meetings, and meetings with the team representatives, experiences were discussed and used for further development of the procedure, for defining the roles of the facilitator and the representatives, for structuring the meetings, and to refine working with the questionnaires and reports.

All teams work in psychiatric hospitals (Table 1) in the Netherlands in different settings, with either adult or juvenile patients. They are of different sizes, and some of the teams are self-organizing.

As intended, in phase I, the team customizes their own questionnaire and process during the first three steps, and also later in phase II, some adjustments are made while working with the program. Examples of items adjusted during the process are: the frequency of monitoring, some of the items in the questionnaire, ways to increase the response rate, and how and when the reports are discussed. The following sections describe aspects that were relevant to the teams in this method: roles and participants, collecting indicators and formulating items, meetings, the questionnaire and reports, response rate, and anonymity.

#### 4.1 | Participation and roles in the pilot teams

In all teams, one or two team members voluntarily took the role of team representative (in Dutch: "kartrekker"). In some teams, non-verbal therapists and team managers also took part in the whole process and all the sessions. In all teams, the manager and/or team coach received the reports, and in most teams, they participated in the discussion of the results.

Clinicians such as psychologists, psychotherapists, and psychiatrists chose not to participate in the sessions of any of the teams. They argued that they work in more than one team. In some teams, this was a subject of discussion; some team-members argued that team-flexibility is a fundamental aspect of the whole multidisciplinary team. Because of the premise that teams are the owners of their program, the decision on participation was taken by the teams themselves.

The role of the facilitator appears to be important. During the pilots, the facilitator-role was fulfilled by an experienced trainer/coach. Guidance and assistance were needed to work with the nine steps program. His attendance was requested to guide the start-up meeting and also later to support and supervise the representatives.

#### 4.2 | Collecting indicators and formulating items

In the first team, the indicators were collected by a small workgroup. In an evaluation, the workgroup members suggested involving a larger delegation or, when possible, the whole team. In the subsequent teams, this was

**TABLE 1** Overview of teams

Team	Org.	Target group	Size	Setting	Self-organizing	Initiative for program
1	A	Adults	43	High intensive care	No	Team + manager
2	B	Adults	20	High intensive care	No	Manager
3	C	Adults	7	Outpatient care	Yes	Team
4	C	Adults	14	Outpatient care	Yes	Team
5	C	Juveniles	9	Inpatient care	Yes/no*	Team
6	C	Juveniles	10	Inpatient care	Yes/no*	Team
7	A	Adults	39	High intensive care	No	Team + manager
8	B	Adults	25	High intensive care	No	Manager
9	B	Adults	28	High intensive care	No	Manager

\*Teams 5 and 6 started as self-organizing teams. Later in the process a manager was assigned.

presented as an option, and most teams chose a delegation or a plenary session. Two teams (5 and 6), for practical reasons, worked together in a cooperative session and made one set of indicators for both. Their questionnaires are identical. Several teams asked for examples of indicators. In these cases, the facilitator provided some examples from other teams.

### 4.3 | Meetings

During the start-up meetings, the team members stated that their awareness of some implicit assumptions had increased. The team members' criteria on learning, cooperation, decision making, and vitality also became explicit, and, by naming the indicators, team members were more readily able to recognize and act on them. There were several team discussions about processes going on under the surface.

Variations emerged during work with the program, for example, teams organized different follow-up meetings. Some teams preferred to work in team sessions at the design stage, whereas other teams chose meetings with delegations or representatives. Most of the teams discussed their reports as part of regular team meetings, while others used the program as the central theme of teambuilding sessions.

### 4.4 | The questionnaire and report

Most teams use their questionnaire monthly, but two teams use longer intervals (6-12 wk). The team members indicate that the report provided sufficient input for analyses but was difficult for some members to read. That is why the design of the report was improved during the pilot and more graphic elements were added. Other additions were the headings "increased," "decreased," and "highest" and "lowest" scores.

### 4.5 | Response rate

A point of attention in the teams is the average response rate (RR) of 62% to the monthly questionnaire, and the need for reminders from the representatives to get enough response.

For this team-exclusive questionnaire, the representatives expect a high RR realizing that the RR here is not about the validity but is seen as the level of participation and commitment of all of the team members in the program. The RR in itself is seen as an indicator. In an effort to increase the RR, team members were encouraged and reminded by the representatives to fill in the questionnaire. In general the RR to questionnaires is a major concern for researchers. An RR of 35% is average for organizational respondents, and is still declining over the years.<sup>32,33</sup>

### 4.6 | Anonymity

The subject of anonymity was discussed in several teams. The program questionnaire is submitted anonymously, and no data is collected about the respondent; only date and time are registered. Some team members argued that the response and also the substantive exchange of perspectives would benefit when the respondents are known. Others defend anonymity as an important condition for getting reliable and truthful answers. In all teams, the facilitator maintained the anonymity, knowing that, in the case of some team mechanisms, cohesion and conformity limit the freedom of individuals.<sup>8</sup>

## 5 | DISCUSSION

In this article, we have described a program for teams to maintain and reflect on their flexibility by discussing the premises of the program, the program in nine steps, and the first experiences of teams with the program. Knowing

that team members who work shoulder to shoulder and watch each other's backs are at risk of developing rigidity, we aimed to help teams to prevent this. In the program, team members define, in a self-directing manner, indicators of their changes in flexibility. The program is intended to facilitate teams to talk about rigidity and take appropriate actions and interventions to maintain or restore their flexibility. We aim to lay foundations for the further development of methods that can help teams recognize and respond to these processes going on under the surface. We explored whether the program, refined and co-created with the members of the first team, offers sufficient support for the nine teams to work independently. The question was discussed of what the teams need to work with the program, and whether the nine steps provide enough guidance. The pilot shows that the steps are a helpful framework, but that more guidance is needed. The (partly) self-organizing teams use the program for "self-managed" team development and for solving team issues.

As first premise, we mentioned that the teams own their program, and this appears to be a significant factor. The pilot teams customize the program, formulate their items, and fill in their questionnaires at different frequencies, and, by doing so, create awareness and commitment. Teams vary in the way they collect indicators: the role of a workgroup or representatives, the frequency and setting of the sessions, the frequency of the questionnaire, and the interventions. This variation is in accordance with premise one mentioned as a unique and essential characteristic and as a motivator for teams to participate. In the further use of the program and the way it is implemented, its flexibility and customizability are important features. Several teams asked for examples or a catalog of indicators, but this is probably a pitfall. Although formulating the indicators and items for the team-exclusive questionnaire is an intensive process, it is important for the commitment and the awareness of the team members.

The program reports helped the teams to perceive early warning signs, and this confirms the second premise, early recognition. The reports helped the team members to talk about rigidity, define indicators of their flexibility, and to think about appropriate actions. Team members report an increasing awareness, and the fact that processes going on under the surface became more explicit. Nevertheless, it seems that executing the actions and responding to the early warning signs is still very difficult. The help of the facilitator was also needed here. The question was raised of whether a managed or self-reorganizing team is capable of handling these complex mechanisms by itself? The effects of the program as such, used by a team without guidance, remain unclear. Research with more teams, over a longer period and with variations in the way the program is facilitated, can give insight into the level of guidance that is needed. In the pilots, the facilitator had an important role, and the results of the program depend partly on his interventions. Apparently, the mental health workers, experts on human behavior and mental processes, also need help in these matters when it concerns themselves. Perhaps, the self-managing teams do require support from outside the team, for example, by a coach or supervisor. The question is whether the failure of a number of implementations of self-managing organizations in the Netherlands is related to this. This question needs more attention in future research. Other professionals such as psychologists, psychotherapists, and psychiatrists could offer their expertise, but do not always see themselves as part of the team. They did not participate in the pilots. We note that the influence of the teams on the decisions of the psychologists, psychotherapists, and psychiatrists is limited. In some teams, the members had to accept their choices. Nevertheless, they could have a valuable influence on team processes because they have a detached view.

The third premise is the division of the concept of flexibility into four "perspectives." Teams use some of the same indicators in connection with different (or even several) perspectives. Moreover, several indicators and conditions are central to all four perspectives. Because of the prevalence of these indicators in all perspectives, one could argue that perspectives are superfluous because their contents do not arise specifically from any specific perspective, but they are central to teamwork in general.<sup>34</sup> In line with the aforementioned, one could argue for removing the perspectives from the program altogether. However it appears that making behaviors explicit in indicators is an important premise. This is the first step in getting teams to understand how to use the program, and depends upon these four perspectives. It provides a guideline and foundation for creating indicators; the use of perspectives provides the teams with a sense of structure which is important for balancing the flexibility and consistency of the



method itself.<sup>18</sup> This leads to the conclusion that the use of perspectives is a helpful part of the process because it provides a framework.

From a scientific point-of-view, the use of the non-validated customized questionnaires might be seen as a drawback of, or even a flaw in, the program as it is hardly possible to compare the results of different teams. Generalization on the basis of the results is difficult. However, it should be noted and kept in mind that this program is not intended as a research instrument for measuring the flexibility of teams. Nevertheless, it would be interesting to undertake further research into the effectiveness of the program. Another possible step is an evaluation of the program: how did it work for the teams and in which context?

A limitation of the pilot might lie in the combinations of roles; the researcher is also the implementer. This dual role is a characteristic of the action research approach, and is not necessarily or only a weakness, but can also provide different insights<sup>35</sup> and lead to practice-based development.<sup>36</sup>

## 6 | CONCLUSION

The pilot shows that the program and the associated forms and reports are a helpful framework for teams to talk about rigidity, to define indicators of their flexibility, and to think about appropriate actions and interventions for maintaining or restoring their flexibility. The four perspectives not only offer a way to define early warning signs but also provide input for learning loops by showing the results and the following steps for reaching the goals and improving quality. Team ownership and the customizability are important attributes of the program. The pilot also shows that the teams need more help with the nine steps themselves. Ownership is important but not sufficient for taking responsibility as a team. The guidance of a facilitator during the process is needed.

The first results are encouraging. The program supports a team in observing and discussing processes going on under the surface. Team members become aware of their team's indicators, and make the ideals and goals explicit. But there is still no answer as to whether the program can help a team take responsibility for these kinds of processes in a self-directing manner: does it help to cope with difficult team mechanisms? Further research and development are needed to find ways of helping teams to invent and implement interventions independently. In the typically unstable, and sometimes threatening, environment in which the teams work, they can use all the help they can get. If we can maintain flexibility, rigidity is no longer an issue.

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