

**The European Nursing Leadership  
Foundation**



**A Literature Review on Team Leadership**

*(based on a report for the Health Foundation)*

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## **Introduction to the Report**

This report was compiled as part of a literature review on team leadership conducted by the European Nursing Leadership Foundation. It has been reproduced here with the kind permission of the Health Foundation.

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## **Section 1 - Review of the Key Leadership Theories**

### ***1.1 – Introduction to leadership theory***

This section incorporates the main theories on leadership which influence both the thinking within the NHS and within the development for leaders offered by providers. Most of the theory relates to single person leadership rather than team leadership and this reflects our findings that most development within teams occurs for individuals rather than whole teams. The end of this section outlines leadership development and places some context on the theories discussed.

Leadership is not new, indeed Plato refers to a higher function in humans who can lead others to enlightenment and represents an ideal. Ideas such as these have been built upon and extended but it is not until the eighteenth and nineteenth centuries that trait theory emerged where personal traits of individuals which were inherent rather than learned predicted leadership capability.

### ***1.2 - Trait theory***

This theory believes that leaders behave in various ways because they have inherent characteristics or dispositions. There are five predominant characteristics of leadership: Self Confidence, Empathy, Ambition, Self-Control and Curiosity. The theory is that you are born a leader and that leadership cannot be learned. To identify leaders or potential leaders then means that one looks for certain characteristics and appoints that person to a leadership position. This has led to selection procedures being seen as more important than developing people (Hogan et al 1994)

This theory has largely been discredited as no evidence has been found to uncover a consistent list of traits which could distinguish leaders from others. One of the problems is that leaders who are successful in one field can be unsuccessful in another, whereas trait theory would suggest that they will be universally successful. A dramatic example of this was the influx of private sector managers and military officers who were brought into the NHS in the late 1980s after the Griffiths Report. Although many of them had had successful

management careers outside the NHS, they found it difficult to work in the new culture and the majority left the NHS soon afterwards.

Whilst trait theory may have been discredited it is largely responsible for the views that only certain people can be leaders and such attributes as charisma are essential. Instead theories have become more concerned with context emphasising that the needs of the situation such as war or adversity would call forth the leader within and the correct leader would therefore emerge.

### ***1.3 - Situational (Contingency) Theory***

The next evolution in leadership thinking was situational theory. This theory, sometimes also called contingency theory, emphasises that leadership emerges in different situations to suit different needs and different environments. This idea was developed further by Blanchard and Hersey (1976) who argued that as well as adapting style to different contexts, leaders need to behave differently to suit the needs and maturity of their followers and there is no best way to lead or style of leadership. They argue that leaders need to develop a range of leadership approaches and be able to diagnose which approach to use in a given situation.

One strand of situational theory distinguishes between task and relationship centred leaders and was based on a managerial grid developed by Blake and Mouton (1964, 1978). John Adair (1993) is another author who has used a diagrammatic model of functional leadership to represent the needs of the task, group and individual when relating to leadership. This approach has been used widely in practice in the NHS and in particular as a corner stone of the Leading Empowered Organisations (LEO) national programme.

There are a number of criticisms of this theory such as Handy (1993) who argues that this confuses leadership style with situational decision making. Elliott & Walker argue that this approach is politically naïve as it contains a narrow definition of the impact which influence plays in the decision making process and in exercising leadership (Elliott & Walker, 2003). Many of the critics of situational theory point out that there is an assumption that leaders have the ability to change styles depending on their environment, but there is little evidence to support this assertion.

### ***1.4 - Transactional and Transformational Leadership***

The idea of transformational and transactional leadership was first developed by James McGregor Burns in 1978 and later developed by Bass and others. Transactional leadership approaches followers with the intent of exchanging one thing for another (i.e. using financial and status incentives). Transactional leadership is premised on motivating followers by some form of instrumental exchange, either a monetary or symbolic reward system. The focus is on the needs of the task and the organisation and how followers can be used to achieve

those aims. There is little focus on the explicit needs of the followers. Bass et al (1987) argued that transformational leadership is universally applicable and that regardless of culture, transformational leaders inspire followers to transcend their own self-interests for the good of the group or organisation (Bass et al 1987). Transformational leadership is seen as being preoccupied with the development of followers rather than the achievement of targets (transactional leadership) and has been equated in some books as equivalent to “leadership” as opposed to transactional leadership which is equated to “management”.

### ***1.5 - Leadership and Change***

One of the most influential writers on leading change is Kotter (1998, 1996). Indeed it is claimed that his Harvard Business Review paper is the most frequently read of all leadership articles. Kotter argues that whilst not mutually exclusive management and leadership are different. Management is about planning, budgeting and goal achievement and organising. Leaders operate through a web of relationships and Kotter prescribes an eight step formula for achieving change through leadership.

1. increase urgency about the need for change
2. build the guiding team
3. get the vision right
4. communicate for buy-in
5. empower action
6. create short term wins
7. don't let up
8. make change stick

Kotter also claims that large numbers of people are needed to make change happen rather than any one person and there needs to be a culture of leadership within the organisation.

Kouzes and Posner (1987) have sought to show that leadership skills can be learnt and used interviews with hundreds of managers to come up with a five step process in which leaders get things done.

1. challenging the process and encouraging others to take risks
2. inspiring a share vision
3. enabling others to act
4. modelling the way
5. encouraging the heart

Applying these five steps means that leaders need to learn how to become a positive force. Kouzes and Posner also developed the Leadership Practices Inventory which is a psychometric tool to measure leadership behaviours.

## **1.6 - Leadership for healthcare professionals**

One of the difficulties of looking at leadership for healthcare professionals is that most theories were not developed within a healthcare context. Usually the theories were developed in a business context and were then applied to healthcare. Also, the bulk of published research on healthcare leadership has very little evidence of any impact on improved patient care or organisational outcomes (Vance & Larson, 2002).

There are a number of leadership writers who have influenced the development of healthcare leadership, often as the underpinning model for courses and development programmes.

Covey (1987) has been one of the most influential writers on Leadership for healthcare professionals since the advent of national programmes (e.g. LEO, RCN Clinical Leaders Programme, etc) where much of the practice is based upon his principles. Covey outlines a process of increasing maturity within leadership which moves from dependence towards a state of interdependence. He outlines relationships built upon mutual trust and respect for others and describes an emotional bank account where deposits must be made before withdrawals can be taken. In a spirit of renewal Covey defines the need for self care and what he calls “sharpening the saw”.

Beverly Alimo-Metcalfe is a key writer on transformational leadership in the NHS and has developed tools for assessing transformational leadership. Alimo-Metcalfe (1988) argued that earlier definitions of “leadership”, as well as the instruments to measure leadership, have been derived from predominantly or exclusively male managerial population. In her study, the explicit intention was to include a substantial proportion of women from whom constructs of leadership were elicited by conducting interviews, as well as to include women in the sample on whom the draft questionnaire would be piloted. This process led to a somewhat different transformational leadership construct.

## **1.7 - Heifetz and adaptive leadership**

Heifetz and Linsky (2002) outline two types of challenges which face organisations and call them technical and adaptive challenges. Technical problems are ones which people already have the ability, knowledge and procedures to solve. Adaptive challenges cannot be solved by existing knowledge and techniques but need “experiments, new discoveries, and adjustments from numerous places in the organization or community.”

These are useful distinctions between management problems and those which require leadership and the authors state that the failure of leadership is most often because adaptive challenges are treated as technical problems. Adaptive challenges require engagement, presence, time and expert communication skills.

Examples of such challenges are those of institutional behaviours and beliefs such as racism and changing beliefs and values of those in organisations. One example could be that within a team of valuing the voices of junior staff in team meetings. This would challenge the view that those with more authority knew more. A technical solution might be that these staff were given a slot on the agenda at team meetings. A more adaptive solution might be a discussion about hierarchy within the team and a challenge to beliefs about age, experience and wisdom. This would require much more time, self knowledge and potential conflict than the technical solution but would produce more concrete results if handled well.

### ***1.8 - Drath and the limitations of personal dominance and interpersonal influence***

Drath (2001) presents an interesting critique on the leadership theories of personal dominance (trait theory and charismatic leadership) and interpersonal influence (transformational leadership, transactional leadership and contingency leadership). What Drath argues is that there are technical problems and situations which can be solved using a personal dominance model, i.e. where a leader initiates action and controls the behaviour of others. He also argues that there are technical and adaptive problems and situations where an interpersonal leadership approach is appropriate, i.e. where collective action is required and where a group needs to be convinced and motivated to act in a certain way.

Both of these approaches assume that the leader knows the direction that the group needs to go in and how the problem needs to be solved. These approaches fail however when the leader does not know what the solution is or the direction needed. In this circumstance, Drath argues that leadership needs to involve relational dialogue. This is a process whereby a leader creates an environment for a group to explore a problem and collectively begin to try and solve it.

Although his theories can sound “woolly” and unfocussed, they do begin to address why some leadership approaches continually fail. For example, technical approaches in the NHS tend to involve mergers, budget cuts, management reorganisation and restructuring. Although these approaches have solved some technical problems, they have failed to solve more difficult adaptive issues such as:

- Real user accountability in health services
- Ethical rationing decisions
- Removing institutional racism
- Growing demand for healthcare
- Health inequalities

Drath argues that to make progress in these areas, leaders need to work with groups and organisations and facilitate a collective process of dialogue and sense making involving:

1. Make sense of reality
2. Lead across world views
3. Make sense of new subjects
4. Develop shared meaning-making

This theory examines the nature of relationships and the dialogue of leadership rather than focussing on any one individual and this lends itself well to any discussion of leadership within teams.

### ***1.9 - Developing Leaders and Leadership - defining leadership development***

Yukl (1998) points out that leadership and management are different but interrelated topics. Wexley & Baldwin (1986) describe management development as primarily management education and training with an emphasis on acquiring specific types of knowledge, skills and abilities. This approach tends to involve the application of proven solutions to known problems. Some of the development offered within the NHS as leadership development has actually been management development. In particular the General Management Training Scheme (GMTS) and the Chief Executive development programme offered by the NHS leadership centre.

McCauley et al (1998) define leadership development as “expanding the collective capacity of organisational members to engage effectively in leadership roles and processes”. Keys & Wolfe (1988) describe leadership processes as those that enable groups of people to work together in meaningful ways whereas management processes tend to be position and organisational specific.

As Fielder (1996) points out, historically leadership development assumes an individual concept of leadership, where a distinction can be made between the “leader” and followers” and so development has consisted primarily of training individuals in interpersonal skills and abilities. This kind of approach ignores over 50 years of research showing leadership to be “a complex interaction between the designated leader and the social and organisational environment” (Fielder, 1996).

### ***1.10 - Effective Leader and Leadership development***

Day (2001) makes a useful distinction between leader development and leadership development, characterised by the table below:

	Leader development	Leadership development
Capital type	Human	Social
Leadership model	Individual <ul style="list-style-type: none"> <li>• Personal power</li> <li>• Knowledge</li> <li>• Trustworthiness</li> </ul>	Relational <ul style="list-style-type: none"> <li>• Commitments</li> <li>• Mutual respect</li> <li>• Trust</li> </ul>
Competence Base	Intrapersonal	Interpersonal
Skills	Self awareness <ul style="list-style-type: none"> <li>• Emotional awareness</li> <li>• Self-confidence</li> <li>• Accurate self-image</li> </ul>	Social awareness <ul style="list-style-type: none"> <li>• Empathy</li> <li>• Service orientation</li> <li>• Political awareness</li> </ul>
	Self-regulation <ul style="list-style-type: none"> <li>• Self-control</li> <li>• Trustworthiness</li> <li>• Personal responsibility</li> <li>• Adaptability</li> </ul>	Social skills <ul style="list-style-type: none"> <li>• Building bonds</li> <li>• Team orientation</li> <li>• Change catalyst</li> <li>• Conflict management</li> </ul>
	Self-motivation <ul style="list-style-type: none"> <li>• Initiative</li> <li>• Commitment</li> <li>• Openness</li> </ul>	

Looking at this table, it becomes clear that **leader development** is typically focussed on individual-based knowledge and the skills and abilities associated with formal leadership roles. Often the developmental model involves building the personal competence needed to form an accurate model of oneself in order to engage in healthy attitudes and identity development (Hall & Seibert, 1992). The leader development then requires the individual to use their self-model in order to perform effectively in a number of roles.

The main emphasis in **leadership development** is building and using interpersonal competence (Day, 2001). Key aspects of development programmes involve social awareness such as, service orientation, empathy and developing others; social skills such as, building relationships, collaboration, cooperation and conflict management. Conger et al (1999) warn against the tendency within organisations to allow leadership development to become a “haphazard process” where the development aims are unclear, accountability for delivery is blurred and there is a lack of effective evaluation.

It is important that the distinctions between leadership development and leader development should not allow one approach to be considered over the other. As Day (2001) points out, either approach is incomplete by itself. Developing individual leaders without regard for organisational relationships and social context ignores much of the leadership literature and does little to enhance the organisational capacity. Equally, “attempting to build shared meaning systems and mutual commitments among communities of practice without a proper investment in individual preparation runs the risk of placing people in challenging developmental situations that are too far over their heads” (Day, 2001).

## **Section 2 - Review of teams and team leadership approaches**

### **2.1 - Introduction**

This section will examine and evaluate the literature on teams and team leadership. It will also place the theory in context by analysing its effect on team leadership development.

### **2.2 - Definitions and types of teams**

There are a range of definitions and approaches to teams and this section will describe some of the more popular and will conclude with a working definition for this report. Two of the key writers in the field of team leadership are Katzenbach and Hackman.

Katzenbach and Smith (1993) define a team as:

*“A small number of people with complementary skills who are committed to a common purpose, performance goals and approach for which they hold themselves mutually accountable.”*

Hackman (2002) defines a team as having four features:

*“a team task, clear boundaries, clearly specified authority to manage their own work processes, and membership stability over some reasonable period of time.”*

Both of these definitions from leading writers on teams have a number of factors in common, namely a task or common purpose and mutual agreements over management and accountability. Hackman is in favour of team stability and states that teams with stable membership perform better. Hackman, Katzenbach and Smith argue that teams should be small in number and ideally between 4 and 6 members. Many teams within the NHS however are considerably larger than the maximum of 6 which both authors argue is the best size for a team.

Hackman states that members should know who is on a team and whilst this seems common sense, our findings support the fact that in many instances teams within the NHS are loose collections of people who may come in and out of team processes. This applies to teams such as the Cancer networks and General Practitioner (GP) surgeries within Primary Care Trusts (PCTs). For example, many PCTs describe GPs in their clinical community who sometimes come to meetings and sometimes don't and are only occasionally involved in the processes within the PCT. It also applies to some clinicians who consider themselves team members but do not attend team meetings.

Adair (1986) states that a team is a group in which the individuals share a common aim and in which the jobs and skills of each member fit in with those of the others.

Katzenbach and Smith also outline a mix of skills for effective teams and call these complementary skills which are:

1. Technical or functional expertise
2. Problem solving and decision making skills
3. Interpersonal skills

For the purposes of this report we have defined a clinical team as:

***A group of people with a mixture of skills who manage and maintain a common patient case load and work effectively together. Ideally decisions should be made collectively and all members should hold each other to account for their performance and clinical outcomes.***

We feel that this definition encapsulates the key aspects from the literature, whilst giving a strong clinical focus and relating the team to clinical outcomes and patient care.

### **2.3 – Classifications of teams**

Hackman classifies teams in the following ways:

1. **Manager-led teams** – where a team executes a task, but is led by someone who is not part of the team itself. This is effectively a group of staff who are given instructions.
2. **Self-managing teams** – where a team not only executes a task, but is led from within the team and the team monitors and manages its own performance.
3. **Self-designing teams** – have all the characteristics of a self-managing team but the team is able to modify the team design and organisational context. These teams still work within a strategic direction which is established outside the team.
4. **Self-governing teams** – are teams which have all the characteristics of self-managing and self-designing teams but also establish the strategic direction of the team. Boards are sometimes an example of a self-governing team and in the NHS, they are rarely found outside of boards and strategic committees.

Most of the literature tends to focus on self-managing and self-designing teams and these are typically what is meant when people use the word “team” in an organisational context. Manager-led teams have little in the way of team dynamics and are really a group of co-workers. Self-governing teams are rare outside of boards and board development is a very particular and specialist aspect of team development.

Katzenbach (1998) argues that the best senior leadership groups are rarely a true team but can function as real teams when a major event occurs. Boards can optimise their performance by working out when a team effort is required and when it is best to operate under the leadership of the Chief Executive. A board cannot be described as a real team when one or more of the members has the authority to performance manage the others. More importantly argues Katzenbach are the teams and leadership down the line from the Chief Executive.

Katzenbach and Smith (2001) describe two leadership styles, single-leader discipline and team-leader discipline. Single-leader discipline where the team is led by an individual team member and that member either makes the decisions or facilitates the team to make decisions. Team-leader discipline is where an entire team makes decisions collectively. Katzenbach and Smith argue that no one discipline is superior or that one should be used exclusively, but that most teams operate in both styles alternately depending on the situation, the decision and the context.

## **2.4 - Advantages of team working**

According to Enterkin and Court (2001), there are two big advantages that effective teamworking brings to an organisation. Firstly, teamwork has the capacity to empower people to utilise their abilities, which enhances motivation and group cohesiveness; secondly, the use of teams allows managers to focus their attention on strategic issues rather than supervising individuals

Scholtes *et al.* (1996) argue that a team outperforms individuals when:

- the task is complex
- creativity is needed
- the path forward is unclear
- more efficient use of resources is required
- fast learning is necessary
- high commitment is desirable
- co-operation of others
- the task or process is cross-functional.

Katzenbach and Smith (1993) summarise the advantages of teamwork as follows:

- Teams bring together complementary skills and experience that exceed those of any individual on the team. This fact enables teams to respond to multifaceted challenges like innovation, quality and customer service.
- In jointly developing clear goals and approaches, teams establish communications that support real-time problem solving and initiative.
- Teams provide a social dimension that enhances the economic and administrative aspects of work.
- Teams have more fun.

They also argue that teams are not the solution to everyone's future and current needs and will not solve every problem. They also state that when misapplied they can be "wasteful and disruptive". This is important to note when looking at the context and environment for clinical teams within the NHS.

## ***2.5 - Team performance and leadership***

Katzenbach and Smith define the high performance team as one where there is a strong personal commitment to one another's growth and success. Kur 1996 defines high performance teams as consistently "satisfying the needs of customers, employees, investors and others in its area of influence." Kur agrees with Katzenbach and Smith's analysis of the requirement for interpersonal relationships by describing them as human-orientated.

Rickards and Moger 1999 define seven factors of high performance teams, namely:

1. Strong platform of understanding
2. Shared vision
3. Creative climate
4. Ownership of ideas
5. Resilience to setbacks
6. Network activators
7. Learning from experience

Kipp & Kipp (2000) have identified a useful six-point framework in examining the relative "health" of a team:

- (1) Goals - What constitutes "success" for us in this situation and overall?
- (2) Role - What is expected of us and what do we expect of each other?
- (3) Rules - What are our agreements on decision making, work ethic, followthrough, etc?
- (4) Relationships - How do we handle conflict, ambiguity, rumor, secrecy, trust?

- (5) Results - How do we determine day-to-day performance?
- (6) Rewards - What is in it for us individually and collectively?

Although these can seem very simplistic, they often unearth the real team dynamic and team processes. We have encountered groups who are described as an effective self-managed team, but when interviewed, it becomes clear that the team is really a group of clinicians who are controlled and directed by a single dominant leader. This pattern is often found in hospital medical teams, where a single consultant dominates the team in terms of problem-solving and decision-making. The other members of the team implement the consultant decisions.

Many researchers argue that there are some influential factors for the improvement of team effectiveness, such as leadership (Kahai, Sosik & Avolio, 1997; Schminke & Wells, 1999), team formation (Early & Mosakowski, 2000), team structure (Stewart & Barrick, 2000; Wang, 2001) and team member's characteristics (Barrick, Stewart, Neubert & Mount, 1998). Among these influential factors of team effectiveness, Parker (1990) argues that the variable of leadership is the most important factor impacting on team effectiveness. Parker does not however outline which leadership style is needed for enhancing team effectiveness.

Kets De Vries (1999), research into Pigmy society suggested seven principles of effective teamwork:

- (1) Members respect and trust each other.
- (2) Members protect and support each other.
- (3) Members engage in open dialogue and communication.
- (4) Members share a strong common goal.
- (5) Members have strong shared values and beliefs.
- (6) Members subordinate their own objectives to those of the team.
- (7) Members subscribe to "distributed" leadership.

According to Kets De Vries (1999), many practices of Pigmy society "are a model of effective behaviour".

There are very few measures in place within the NHS for monitoring team effectiveness. They are usually judged against national targets for patients within their area such as waiting list targets. There are individual performance measures in place within most areas but we have found little evidence of whole team performance measures.

According to the argument of Parker (1990), the team leader is the key factor to cause impact on team effectiveness. A good team leader should set clear goal and vision for his or her team. At the same time the team leader should be able to stimulate team members to create the team spirits of labour division and cooperation.

Some literature has focussed on the impact of various leader styles on team performance. Waldman (1994) found that transformational leadership approaches improve innovation within multi-functional teams. Glickmman et al (1987) differentiate between team acting with a “teamwork” focus on performance as opposed to a “taskwork” focus, in other words how much activity and effort supports the quality of the interpersonal relations, communication, conflict management and cohesion and how much supports the various organisational tasks. Of course some teams develop some of these through close working on tasks, but this is what we would call “accidental teambuilding” rather than planned teambuilding. Dionne et al (2003) identify 3 key teamwork processes:

- **Cohesion** – defined by Shaw (1976) as “the degree to which members of the team are motivated to remain on the team”. Highly cohesive teams tend to have less absenteeism, high involvement in team activities and high levels of member co-ordination during team tasks (Morgan & Lassiter, 1992).
- **Communication** – which includes factors such as increased listening, openness to suggestions and effective feedback. Open and easy communication within a team is critical for accomplishing long-term goals as well as daily team activities (Zander, 1994).
- **Conflict management** – Conflict occurs whenever two or more members of a group or two or more groups disagree (Dionne et al, 2003). Conflict only becomes harmful when tensions within or between groups stop members from thinking clearly or making sound decisions (Zander, 1994). Not all conflict is harmful though and it may awaken members to alternate points of view, stimulate creativity in problem-solving and decision-making (Dyer, 1987).

Miles & Mangold (2002) found that team member satisfaction was influenced by the extent to which communication within the group was open and the team leaders’ performance. Team leader performance was influenced by the team members’ satisfaction with their leaders’ ability to resolve conflicts and the teams’ openness in communication.

Nerkar et al (1996) identified two satisfaction-related constructs that appear to have a positive impact on team performance:

- **Instrumental satisfaction** focuses on team members’ satisfaction with their teams’ accomplishments, and
- **Social satisfaction** pertains to the interaction that occurs among team members.

Ancona & Caldwell (1992) found that the type rather than the amount of external communication that determines team performance. They identified the different aspects of performance enhanced by internal group processes compared with external group processes. They found that whereas good internal group processes improved team-member satisfaction and team performance, organisational performance was improved by team's external group processes. Where teams focus is their internal dynamics and processes, this can improve team performance and the team will assess its own performance as high, at the same time as the organisation may not. These "isolationist teams create impermeable boundaries that allow them a cocoon-like existence .... Internally, they work efficiently and cohesively, a cycle that reinforces the benefits of ignoring the outside world" (Ancona & Caldwell, 1992).

## ***2.6 – The impact of effective team working in the NHS***

The NHS is moving from a service focussing on acute inpatient care to one which is more inclusive of patients and users of the service and places more emphasis on care within community settings. With the shift in the focus of care the need for more team performance and better team leadership has increased.

Historically teams within the NHS were clinical teams which operated under the direction of a consultant or doctor and this has remained the case in many settings. The focus has changed however to nurse led teams and teams which include health and social care components. Clinical teams themselves are becoming more diverse and our case studies reflect the multi professional membership of many teams in the NHS.

There are several areas in which the use of effective team working has been seen to have an impact on healthcare, namely in terms of reduced hospitalisation times and costs, improved service provision, enhanced patient satisfaction, motivating staff and team innovation.

Sommers et al (2000) compared primary health care teams (PHCT) with 18 private GPs working in isolation. They concluded that the teams lowered hospitalisation rates and reduced physician visits while maintaining function for elderly patients with chronic illness and functional deficits. Ross et al (2000) found that nurses who worked in teams reported that there was increased and more cost effective use of specialist skills, more streamlined patient care and less duplication of services.

Hughes et al (1992) noted that increasing access to home care using hospital based teams improved patient and carer satisfaction amongst terminally ill patients in the US. Wood, Farrow and Elliott (1994) found that primary care teamworking improved staff motivation and West and Wallace (1991) found that team collaboration, commitment to the team and tolerance of diversity were positively related to team innovativeness.

What is interesting is that there are some environments where excellent clinical care can be delivered in spite of poor teamwork, particularly where the work is very technical in nature, length of stay very short and care is delivered in a single setting, for example in Operating theatres and Accident & Emergency. That is not to say that there is not often excellent teamwork to be found in these environments, but bullying hierarchical structures can function in these areas and still produce good clinical outcomes.

In clinical areas where the patient is more involved and care takes place over a longer period of time and in multiple settings, for example, primary care, mental health and learning disabilities, good teamwork tends to be synonymous with good clinical care. Bullying hierarchical structures do not work effectively in these settings and are tolerated far less.

Borrill et al (2000) were commissioned by the Department of Health to conduct a study into the effectiveness of clinical teams in the NHS. The team surveyed community mental health teams and secondary care teams using a model of team effectiveness in terms of inputs, outputs and group processes. Some of their key findings were:

- There is a significant and negative relationship between the percentage of staff working in teams in acute hospitals and the mortality rate in those hospitals
- The quality of teamwork is directly and positively related to quality of patient care and innovation in healthcare
- In teams characterised by clear leadership, high levels of integration, good communication and effective team processes, team members have good mental health and low stress levels
- Effective and innovative teams are characterised by a pattern of reflexivity and collectively and individually take time out to review, plan and implement actions
- Leadership in clinical teams is critical but often absent
- In more developed teams distributed leadership amongst different functions is associated with higher levels of effectiveness, innovation and better quality teamwork
- Clear shared leadership is also associated with better team processes
- Conflict over leadership is disastrous for teams

Borrill et al concluded that healthcare teams need group centred leaders who see responsibility as shared by both the leaders and the team; where control over final decisions is vested in the team; where leaders position power is de-emphasised; where the leaders perceives the team as a collective entity and shares responsibility for shaping the tasks of the team.

## **2.7 - Building teams**

The purpose of teambuilding interventions is to enhance performance by improving the processes that characterise the work of the group. While programme specifics vary with the needs of the client, all sessions should target communication styles, problem solving, decision making, conflict management and the appropriate use of power as key processes meriting attention.

Kipp & Kipp (2002) suggest that there are four good reasons for teambuilding each of which calls for very different strategies:

- (1) New group formation and improved relationships.
- (2) Problems in group dynamics.
- (3) Barriers to goal attainment.
- (4) Resolution of goals and strategy.

One of the most popular team development models is Tuckman's 1965 "Forming Storming Norming Performing" team-development model. Dr Bruce Tuckman published his Forming Storming Norming Performing model in 1965. He added a fifth stage, Adjourning, in the 1970's. The Forming Storming Norming Performing theory is an elegant and helpful explanation of team development and behaviour.

Tuckman's model explains that as the team develops maturity and ability, relationships establish, and the leader changes leadership style. Beginning with a directing style, moving through coaching, then participating, finishing delegating and almost detached. At this point the team may produce a successor leader and the previous leader can move on to develop a new team.

Tuckman's forming storming norming performing model - original model  
The progression is:

- Forming
- Storming
- Norming
- Performing

### **Stage 1 - Forming**

High dependence on the leader for guidance and direction. Little agreement on team aims other than received from the leader. Individual roles and responsibilities are unclear. The leader must be prepared to answer lots of questions about the team's purpose, objectives and external relationships. Processes are often ignored. Members test tolerance of the system and the leader.

## **Stage 2 - Storming**

Decisions don't come easily within group. Team members vie for position as they attempt to establish themselves in relation to other team members and the leader, who might receive challenges from team members. Clarity of purpose increases but plenty of uncertainties persist. Cliques and factions form and there may be power struggles. The team needs to be focused on its goals to avoid becoming distracted by relationships and emotional issues.

## **Stage 3 - Norming**

Agreement and consensus is largely forms among team, who respond well to facilitation by the leader. Roles and responsibilities are clear and accepted. Big decisions are made by group agreement. Smaller decisions may be delegated to individuals or small teams within group. Commitment and unity is strong. The team may engage in fun and social activities. The team discusses and develops its processes and working style. There is general respect for the leader and some of the leadership is more shared by the team.

## **Stage 4 - Performing**

The team is more strategically aware; the team knows clearly why it is doing what it is doing. The team has a shared vision and is able to stand on its own feet with no interference or participation from the leader. There is a focus on over-achieving goals, and the team makes most of the decisions against criteria agreed with the leader. The team has a high degree of autonomy. Disagreements occur but now they are resolved within the team positively and necessary changes to processes and structure are made by the team. The team is able to work towards achieving the goal, and also to attend to relationship, style and process issues along the way. Team members look after each other. The team requires delegated tasks and projects from the leader. The team does not need to be instructed or assisted. Team members might ask for assistance from the leader with personal and interpersonal development. The leader delegates and oversees.

Tuckman refined his theory around 1975 and added a fifth stage to the Forming Storming Norming Performing model - he called it Adjourning, which is also referred to as Deforming and Mourning. Adjourning is arguably more of an adjunct to the original four stage model rather than an extension - it views the group from a perspective beyond the purpose of the first four stages. The Adjourning phase is certainly very relevant to the people in the group and their well-being, but not to the main task of managing and developing a team, which is clearly central to the original four stages.

## Stage 5 - Adjourning

Tuckman's fifth stage, Adjourning, is the break-up of the group, hopefully when the task is completed successfully, its purpose fulfilled; everyone can move on to new things, feeling good about what's been achieved. From an organizational perspective, recognition of and sensitivity to people's vulnerabilities in Tuckman's fifth stage is helpful, particularly if members of the group have been closely bonded and feel a sense of insecurity or threat from this change.

Kipp & Kipp (2002) also argue that while there are no absolutes where organisational behavior is concerned, they suggest the following lessons based on their experience:

- Teams are not well served by "psychotherapizing" individual members publicly or one by one. Serial executive coaching is not teambuilding.
- Removing "bad actors", while sometimes long overdue, seldom alters group dynamics. It just creates a vacancy.
- Time together in and of itself changes nothing. Teams that have been together for years are no more effective than when they started unless they have worked on how they work.
- Nothing gets better without follow-up behavioral contracts; periodic interventions; process checks and the like.
- There is no substitute for emotional maturity.

Teams can be further classified by their management and leadership style. Katzenbach and Smith outline five types of team which they place within a team performance curve.

1. Working group – interaction to share best practice and perspectives with decisions made to help each individual perform within their area of responsibility
2. Pseudo team – there may be a performance need but has not focussed on collective performance and is not really trying to achieve it
3. Potential team – there is a significant performance need and is trying to improve performance impact
4. Real team – people are equally committed to a common purpose, goals and working approach for which they hold themselves mutually accountable
5. High performance team – meets all the above criteria and is deeply committed to one another's personal growth and success. (Katzenbach and Smith, 1993)

They suggest that the highest performance change is between the potential and real team. These are useful classifications when looking at teams within the NHS.

Many of them are actually working groups, pseudo or potential teams. This does not necessarily affect performance and may indeed be the best way of delivering a quality service for particular groups of patients or disease groups.

## **2.8 - Evidence base for leadership interventions**

There are a range of leadership interventions which are used to develop team and individual leadership.

The following activities are often combined to form leadership development programmes:

- Classroom-based learning
- 360-degree feedback
- Coaching
- Mentoring
- Networks
- Assignments or secondments
- Action learning sets

The following section will look briefly at what these activities are, how they impact on leadership development and what the evidence-base is.

Green (2001) stresses the importance of leadership rather than management in the context of team development and refers to Rajan's (1996) study of leadership in over 500 organisations. This shows five development modes ranked according to how valuable they were perceived to be:

1. Coaching and mentoring
2. Sideways moves
3. Challenging assignments that stretched their capability
4. Networking with peers
5. Formal training

This section will look at the evidence in terms of its impact on assessment, challenge & support. This is a framework developed by Van Velsor, McCauley & Moxley, (1998) which identifies the key aspects of a development programme as the extent to which it assesses, challenges and supports.

### **Classroom-based learning**

Classroom-based learning is still extremely popular for many organisations in the NHS and private sector. One of their biggest limitations is the lack of behavioural change upon return to the workplace and the difficulty of applying theoretical training into the workplace (Day, 2001). According to Dotlich & Noel (1998), traditional classroom-based training has limited effectiveness in developing

leaders and most lessons learned from such programmes rarely last much beyond the end of the programme. Soon after the course ends, participants tend to slip back into established behaviour patterns and there is little sign of any lasting change or developmental progress.

### **360-degree feedback**

360-degree feedback, multi-source feedback and multi-rater feedback are all terms describing a method for systematically collecting the perceptions of an individual's performance from peers, direct reports, supervisors and occasionally other stakeholders (Warech et al, 1998). The growing popularity of this tool is linked to the increasing recognition of the value of self-awareness; however there is nothing that guarantees that feedback will lead to positive individual change. In fact Kluger & DeNisi (1996) found that where 360-degree feedback is used in isolation, that over one-third of studies showed decreased individual performance as a result. This could be because individuals have strong psychological defence mechanisms against unfavourable feedback, or that individuals recognise the feedback as accurate but have no wish to alter their behaviour (Chappelow, 1998). Walker & Smither (1999) found that one key factor that can improve performance is if individuals discuss their feedback with others (particularly upward feedback from direct reports). Day points out that willingness to accept and use feedback on its own is insufficient for change "if the feedback is complex or inconsistent or if the recipient lacks the requisite skills to interpret the data and transfer it into behaving in a different manner" (Day, 2001). 360-degree feedback can be particularly useful when combined with executive coaching as the next section will illustrate.

### **Coaching**

Hall et al (1999) define coaching as practical, goal-focussed forms of one-to-one learning and behavioural change. The objectives of the coaching are typically focussed on improving individual performance and enhancing organisational effectiveness and is an ongoing process rather than a discrete event. Coaching tends to be underpinned by a development model (e.g. diagnosis, coaching and maintenance/support (Hellervik et al, 1992)). Although most people benefit from coaching interventions, Thompson (1987) identified that in one study, 75% of participants in a coaching programme were "in some danger of derailing when they began the coaching process". Hellervik et al (1992) reinforced this when they pointed out that typical motives for referral to a coaching programme are to remedy poor performance. This can create a stigma around a coaching programme which organisations need to be aware of, although this can be mitigated by providing coaching to an entire organisational level or an entire team. There is little empirical evidence of the impact of coaching on performance but a great deal of case study material (Kilburg, 1996). One notable exception is the study by Olivero et al (1997) which showed that coaching as a follow-up to a

public-sector training programme increased productivity by 88% compared with the programme alone.

## **Mentoring**

Mentoring has a long history in the field of personal development. In formal organisational programmes, it tends to involve the pairing of a junior manager with a more senior manager or executive outside of the direct chain-of-command. There is a degree of overlap between coaching and mentoring and a number of organisations as well as development providers do sometimes use the words interchangeably.

## **Networks**

Networking can be useful at breaking down barriers between areas within an organisation and between organisations themselves. It exposes participants to new thinking and can challenge basic assumptions about what “we think we know”. Sometimes networks evolve from members with shared interests or work areas but also often evolve following training or development activities. Day (2001) points out that there is some evidence that networks can enhance innovation and problem-solving capacities.

## **Assignments or secondments**

McCauley & Brutus (1998) have shown that job experiences can help individuals learn, undergo personal change and acquire leadership capacity through roles, responsibilities and tasks encountered in their jobs. McCall et al (1988) found that assignments and secondments were “particularly helpful to managers in learning about building teams, how to be better strategic thinkers and how to gain valuable persuasion and influence skills. The primary development activity here is challenge with occasional support, but it is also key that the initial assessment is accurate to match individuals with experiences that meet their specific development needs. It is important that the development aspects of the assignment are kept in mind, or there is a danger that the focus shifts on how the individual performs in their new role rather than what learning or development has taken place.

One overlooked factor in leadership development is negative experiences or hardship. Moxley (1998) points out that often these negative experiences promote great learning and can trigger self-reflection. The ways in which senior members of the organisation respond to failure can be instrumental in fostering a learning climate. Hollenbeck & McCall (1999) found that too few senior managers take a developmental view of failure and often focus on performance at the expense of development, even though effective learning from mistakes can pay massive dividends in terms of future performance.

## **Action learning sets**

Action learning is based on the assumption that people learn best when working in real-time organisational problems (Revans, 1980). According to Drath (1998), “because action learning is primarily a generative practice, each application is a unique performance of sorts in which the participants collectively construct social meanings and shared realities in a community of practice”.

Brockbank et al (2002) have also highlighted the use of reflective learning in a team context and demonstrated its tremendous potential for improving team performance.

## **2.9 - Evaluating leadership development programmes**

Donald Kirkpatrick’s model is often used when evaluating development programmes (Kirkpatrick, 1975). He describes 4 levels of evaluation as follows:

### **Emotional reaction**

This is the individual’s attitude at the end of a training or development session. This can be used to assess the individual’s general attitudes, expectations and motivation as well as providing useful feedback on how well the training has been delivered. One of the most common ways this is assessed is via a post-course questionnaire which has received widespread criticism, particularly regarding their accuracy and bias.

### **Achieved learning objectives**

This is typically an end-of-course evaluation to measure the knowledge or skills gained during the training intervention. This type of measure often involves a pre- and post-test comparison so that the knowledge and skills gained can be explicitly measured.

### **Behavioural changes**

Although the first two measures can be measured immediately following the training intervention, behavioural change requires a time interval before it can be assessed. Because such change is most often recognised in performance, its measurement in training and development is usually linked to existing organisational performance appraisal systems. One limitation of this approach though is it is difficult to tease out the various factors contributing to behavioural change which may have little or nothing to do with any development programme.

## Impact on the organisation

This measurement is based on the precept that training and development should impact on the organisation and its performance or culture. In practice, this tends to take the forms of existing organisational measures (complaints, productivity, hospital-acquired infections, etc). Measuring the impact of a development or training programme or initiative is inherently difficult, due to the complexity of the organisational structure and its interaction with the environment. In practice, this measurement tends to be an aspirational target and there are precious few examples of where this impact has been reliably demonstrated.

Chan, Pearson & Enterkin (2003) produced empirical evidence to support the impact on team performance of team rather than individual learning. "Leadership development should also recognise the local and national contexts within which leaders operate. However, learning about leadership practice in other countries provides a 'mirror' to help develop new insights into practitioners' own contexts." (Bush & Glover, 2004)

There is actually very little evidence on the outcomes of leadership development programmes that have been run in the NHS. Where it has taken place, it tends to look at emotional reactions and the meeting of learning objectives and is typically measured immediately after a development programme or intervention. Behavioural change and organisational change are the drivers for most leadership development initiatives and yet are rarely, if ever, measured by providers of leadership development programmes or organisations who commission or receive such programmes.

### **2.10 - Organisational support**

Castka et al 2001 state that the support of the organisation is crucial to all activities involving "change". The organisation or its management should be responsible for:

- *Creating the organisational culture*, which supports and encourages team empowerment, experimentation, creativity and innovation, win-win approach to conflicts, failures and mistakes, and ensures open communication and the creation of communication channels.
- *Team formation*, i.e. group size, group composition, team training and the purpose of the team.
- *Providing a supportive environment*. The team is supported by senior management and by the person to whom the team reports. An important aspect is the autonomy of the team, which is necessary for its development (Nonaka and Takeuchi, 1995; Peters and Waterman, 1982).

Furthermore, the organisation has to make possible access to resources - time, money, data, information, knowledge, talents and materials (Senge *et al.*, 1999; Meyer, 1998). Senge *et al.* (1999) strongly advocate the use of an outside facilitator, who speeds up the process of team development and team learning. The supportive workspace also is of significant import. This fact is strongly advocated by both Peters (1992), and Nonaka and Takeuchi (1995). They argue that the supportive workplace environment is crucial for knowledge exchange among team members.

- *Monitoring team performance* based on measurement of the key performance indicators, which should be mutually agreed on by team and management.
- *Team reward and appraisal system.*

Where there is organisational support for a development initiative and particularly a commitment to evaluate and support follow-up, it is much more likely that the development programme will have a positive benefit. Given the level of investment of many programmes, it is surprising that there is little attention given them at senior and board levels and little evaluation beyond the immediate post-programme questionnaire.

## **2.11 – Doctors and clinical team leadership**

A number of writers have referred to the particular issues surrounding doctors and both team leadership and leadership in general (Buchanan *et al.* (1997), Burgoyne & Lorbiecki (1993), Cavenagh (2000), Elston (1991), Fisher & Best (1995), Fitzgerald (1994), Hunter (1992), Mumford (1989) and Smith (1992)). Doctors have historically been somewhat difficult to engage in leadership development and teamworking programmes and do require some special consideration. A particularly interesting unpublished MPhil thesis explores the history and development of the leadership function in medicine and how doctors view leadership and management roles (Mottram, 2002).

Mottram found that doctors often use the term management to describe leadership and that doctors have 5 different constructs in mind when they use the word “management”, namely:

- Administration and support to clinical activity
- Being “in charge” of a service
- Management processes
- Personality and whether someone is “likeable” and has good judgement
- Leadership and teamworking

Young found a 30:70 split amongst doctors, with 30% being receptive to the idea of management being part of their role and 70% who are “antipathetic to

managers” (Young, 1999). The most extreme viewpoint was expressed by Richard Smith (the editor of the British Medical Journal) who wrote:

*“Why should anybody want to fret about budgets, staff and strategy when they could be replacing heart valves, tending to the dying or researching into the molecular pathology of disease? Management is for doctors who are too old and burnt out for anything better” (Simpson & Smith, 1995)*

Mottram also found that the aspect of management which was held in the highest regard was leadership and teamworking. A number of doctors in the study identified close links between leadership and clinical teamworking although they all assumed that the doctor was the leader and were unclear about what constituted good teamwork. A surgeon described his leadership function in his clinical team as:

*“I make all of them involved in what I do, keep them interested which means explaining things ... communicating with them and teaching them ... and make sure that we finish on time” (Mottram, 2002)*

The study found a widespread opinion that doctors are often poor team players and this was reinforced in interviews, particularly around the extent to which multi-disciplinary meetings can become “medical update sessions”. There is often a lack of common understanding about exactly what is a team and what good teamworking should be.

A number of doctors commented about management and leadership training, feeling that they had little impact on their clinical performance and were sometimes a waste of time, e.g. “I have been on a couple of management training courses and they were fun but whether they changed me I don’t know”. One interviewee observed that leadership and personal development training was very different from medical training with its enormous requirement to impart facts and learn knowledge. Very little medical training focuses on communication, interpersonal behaviour and teamwork and this is not required for promotion into senior medical roles.

The study also suggests that (unlike most other professions) in medicine a doctor is often given a medical leadership role and will have the support of his colleagues if he or she “is clinically credible and has served some form of apprenticeship which creates a degree of trust and that this is much more important than their skills or attributes ” (Mottram, 2002).

We spoke to a number of doctors in our site visits about team membership and leadership. They were all extremely keen on improving teamworking if it could be proved to be effective in terms of clinical outcomes. Doctors will often need evidence of the effectiveness of a programme before committing time and energy. The doctors who were involved in team development tried hard to

engage medical colleagues and were delighted when this happened, but were sanguine about non-participation in programmes.

## ***2.12 Conclusions from the literature***

- Effective teamwork can have a measurable impact on clinical care and on organisational outcomes
- Organisational support is key and board-level commitment is likely to be required to continue a development programme
- Programmes should be evaluated in terms of behavioural change as well as organisational outcomes
- On-site leadership development is more effective than classroom-based leadership development
- All team members need to be involved in developing team leadership, not just the team leader
- Doctors should be encouraged to be part of any team leadership programme, but consideration should be given as to whether this is a mandatory requirement.

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## **Appendix A - Tools for evaluating and measuring Team Development, Effectiveness and Leadership**

This is a list of instruments that may be useful in researching the development, effectiveness or leadership of a team.

### ***Focused instruments***

- Team Collaboration Index
- Collaboration & satisfaction about care decisions
- Rating Individual Participation in Teams
- Survey of Team Development
- Team Development Scale
- Team Anomie Scale
- Team Meeting Assessment
- Attitudes Towards Health Care Teams
- Team Skills Scale
- Postmeeting Evaluation Form
- Team Development Rating form

### ***Middle-Range Instruments***

- Meeting Evaluation Scale
- Work-Group-Effectiveness Inventory
- Trust Orientation Profile
- PostMeeting Reaction Form
- The Team Orientation and Behaviour Inventory (TOBI)
- Teamness Index
- Team Development Rating Scale
- Team Integration Measure
- Group-Growth Evaluation Form
- Criteria of Group Maturity
- Team Profile Questionnaire

### ***Broad-Spectrum Instruments***

- Team Effectiveness Critique
- Team Climate Inventory (TCI)
- Team Success Survey
- Team Development Stage Assessment (TDSA)
- Team Maturity Scale
- Modified Family assessment Device for Teams (MFADT)
- TORI Group Self-Diagnosis Scale
- Team Effectiveness Inventory
- Group Development Assessment (GDA)
- Work Group Functioning Module (4)
- Team Excellence Questionnaire

- Factors Influencing Productivity & Excellence in Team Work
- Analysing Team Effectiveness
- Group Effectiveness Scale (GES)
- Survey of Cross-Functional Teams

### ***Full-Spectrum Instruments***

- Individual-Team-Organisation Survey (ITO)
- Team Development Survey (TDS)
- Work Group Characteristics Measure
- Team Assessment Inventory (TAI)
- Team-Review Survey
- Team Effectiveness Profile (TEP)
- Team-Building Assessment
- Team Character Inventory
- Team Effectiveness Checklist
- Team Assessment Worksheets
- Team Effectiveness Dimensions (TED) Survey
- Team Well-being Assessment
- Team Effectiveness Rating Scale
- Team Strength Survey
- Group development questionnaire (GDQ)
- Team Performance Profile