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Leadership in Health Services

Leadership in interprofessional health and social care teams: a literature review

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Background

This paper reports on the results of a critical literature review (Grant & Booth 2009) that aimed to evaluate the evidence and to present an analysis of leadership in Interprofessional Teams in Health and Social Care organisations.

Concerns over leadership in the UK National Health Service (NHS) first became an area of focus in the late 1980's when professional management was introduced (Mackie 1987). When the Labour government came to power in 1997, leadership capacity was recognised as a critical factor in the reform agenda; to modernise the NHS (Goodwin 2000). The Department of Health set up a National Centre for Leadership in 2001 as part of the NHS Modernisation Agency and this led to a plethora of leadership initiatives commissioned by NHS organisations that included public health (McAreavey, et al (2001), a range of leadership frameworks (Bolden et al. 2003) and competency frameworks (Bolden et al. 2006). For nearly two decades, leadership development has been a priority within health care but less attention has been given to the effectiveness of leadership on the outcomes of teams. Reports on health service failures at an organisational level have further regularly identified poor leadership as a contributory factor in criminally negligent care (Keogh 2013, Francis 2013, Berwick 2013).

The Kings-Fund (2011) has consistently calls for replacement of heroic leadership models which focus on the development individuals in favour of an increased focus on shared/collective leadership models and extension of leadership development efforts to all levels. The continuing erosion of professional divisions in intermediate care and

particularly community services has been driven in part by the ambition to create integrated services has enabled health and social care professions to increasingly work together around discrete stages of patient pathways (Ovretveit 1997, Pollard, Miers & Gilchrist 2005, Means, Richards & Smith 2003).

The formation of interprofessional teams has brought the issue of leadership to the fore with the challenge of enabling sometimes large teams of different professionals and differently skilled workers to coordinate their efforts and work more closely together than was traditionally the case. This integration agenda is not straightforward, however, as it fundamentally contradicts many of the fundamental tenets of professionalism (Reeves, MacMillan and Van Soeren 2010), with healthcare leaders sharing responsibility across services, for the delivery and outcomes of care.

Thylefors et al. (2005) developed a useful taxonomy to understand the level of integration of work practices in healthcare teams consisting of a range of professions/disciplines.

"**Multiprofessional**" teams have no focus on collective working. Professionals treat the patient independently, without the input of other team members. This model represents the customary form of healthcare delivery in which doctors traditionally took responsibility for coordinating independent contributions to the care of patients.

Interprofessional working encapsulates the core notion of teamworking, where outputs are measured and based on the collective effort of team members working with the patient. Effective care is accomplished through the interactive efforts of healthcare workers, with some responsibilities shared, requiring collective planning, and decision making (Day 1981, Sicotte, Amour & Moreault 2002).

A study of the effects of multiprofessional and inter-professional team approaches on teamwork; and team effectiveness for rehabilitation teams, found that interprofessional teams showed significantly better results for nearly all aspects of teamwork and team effectiveness measured (Korner 2010).

This paper presents a review of leadership in interprofessional health and social care teams, seeking to identify elements that are characteristic of and/or associated with higher performance and achieving better patient outcomes.

Methods

Critical review is undertaken as a method for enabling new conceptual insights by seeking to embody existing or derive new theory from existing literature (Torraco, R. J. (2016). A potential difficulty with the approach is that the evaluation of contribution is dependent on the type of evidence. In management literature, publications about the topic may be small in quantity, of poor quality, and/or inconsistent in terms of both the application of methods and epistemology (Tranfield, Denyer & Smart 2003).

In addition, systematic reviews in management literature need to relate directly to the context of health and social care (Easterby-Smith et al. 2008) to be considered the best evidence available, even though these may not be rigorous experimental studies of the type normally conducted within the medical sciences, and may even propose theory where no empirical evidence exists.

Review questions/objectives

The specific aim of the review was to describe facets of leadership within interprofessional health and social care teams and generate a thematic framework that explains and develops conceptual understanding of that role.

The review addresses two key objectives. To review:

1. Research and grey literature on interprofessional team leadership in health and social care, to appraise any key theoretical constructs and tested variables.

2. Research and gray literature relating to interprofessional health and social care team working, commenting on interprofessional team leadership.

The search strategy was designed to access peer reviewed, published studies for the period 1994 – 2015. This time period was determined as significant, based on the policy context i.e. Department of Health had begun to focus increasingly only patient pathways and interprofessional working to improve patient care (NHS Plan 2000- http://www.nhshistory.net/nhsplan.pdf) and at the end of the period the Five Year Forward View (NHS England 2014) outlined and consolidated the ambition to commission and provide integrated health care with significant focus on the leadership of new services and ways of working (Ham et al 2016) .

The peer-reviewed databases listed below in Table 1 were searched, together with governmental databases such as the Department of Health, and the NIHR.

Insert table 1 here

A search using all identified relevant keywords and index terms (see Table 2) was then undertaken across all included databases. Hand searching included reference lists of all identified reports and articles, which were screened to identify additional studies and relevant texts in the gray literature referring to interprofessional team leadership in health services. The search was then extended to include any identifiable reference to 'team-working'and interdisciplinary, which were broader than interprofessional, to identify any mention of team leadership in a health context. An additional reason for the extension was in recognition of unqualified or non-professional staff who are part of the teams caring for and treating patients. Finally the search terms identified a range of team and service outcome metrics that refer to the process of care and the impact of care typically using outcomes of service/ team rather than health status or health outcome.

Table 2 below outlines the key search terms and Table 3 provides the terms used for the additional focus on potential outcomes of team leadership within the care context.

(Insert table 2. here)

(Insert table 3. here)

Inclusion and Exclusion Criteria

The critical review aims to develop an evidence-based theoretical understanding of interprofessional team leadership, including conceptual models for practice. It is based on empirical findings or narrative examples from practice, described and/or evaluated. Selection began with an initial screening of the papers by title and abstract utilizing the specific decision rules to identify relevant papers. A set of decision criteria were

developed; to identify relevant papers that would distinguish between leadership theories in healthcare and those particularly referring to interprofessional teams. The initial categories related to main methodology i.e empirical study, qualitative research, or a narrative study, or systematic review. This method sorted papers and enabled authors to select key papers related to the review objectives and enhanced decisions about which papers to include or exclude (Paterson et al. 2001). Further selection identified any papers including reference or outcomes achieved through interprofessional team leadership in health and social care. As there were few papers specifically on this topic, the search was extended to include papers on interprofessional teamwork, again allowing leadership to become the emerging narrative within publications on health care team practice. Due to the dearth of literature on inter* (professional, disciplinary) team leadership publications discussing primary or secondary research on interdisciplinary team leadership, or interdisciplinary team working were included. Papers that had no apparent evidence base were excluded from the review and these included opinion pieces and editorials with particular views of a single author.

A mixed methods quality appraisal tool was then used to evaluate the selected empirical studies and this was also adapted and applied to the descriptions of teams and clinical practice context. Table 4 includes the quality assessment criteria used for the study. Evaluations of leadership or team outcomes and processes were included and the content re-viewed for satisfactory description and relevant content

Insert table 4

Data Extraction and Synthesis

Data extraction was undertaken manually using an excel spreadsheet designed for the purpose of categorising findings. Papers were read and re-read as full text and emergent ideas were identified with key ideas and theories recognised and noted. The Ritchie et al. (1994) 'Framework' approach was adopted to code the data and further analysis was undertaken using the findings from the selected reports (grey literature). This approach was chosen, because it was both rigorous and permitted the analysis of original data but was also open to adaptation and change; allowing methodical treatment of all similar units of analysis and some case comparisons. Principally it was adopted as a means of synthesis that allowed full review of the located data (Ritchie et al. 1994). Following the coding of papers and data extraction into categories a number of preliminary themes were developed. These formed the basis of the framework that could then be used to create some broader, higher order themes and additional data was included, based on agreement with other authors. The framework was continually modified as a deeper understanding of the data was developed as new data was coded and new themes emerged. The synthesis was completed when all data had been incorporated and items checked to ensure that the framework permitted a robust 'container' for the data and permitted a more conceptual analysis of interprofessional leadership.

Results

Searches for Interprofessional Team (working and) Leadership identified a total of 634 texts and after supplementing these searches with relevant papers identified in the interprofessional teamworking literature review and back-chaining through reference

lists, 1419 papers were identified as being of possible interest. All papers contained a combination of the key words utilized in the search from published literature between 1994 to 2015.

Following full text screening, categorisation by methods to exclude opinion pieces and critical appraisal a total of twenty-eight (28) papers were selected. These were deemed to provide an analysis of outcomes from team leadership and proposed a conceptual frameworks of interprofessional team leadership (IpTL), or discussed elements of IpTL in depth.

The findings of the analysis of these papers is set out below and summarised in Table 5. Further explanation of the relevance of each category is also added below to explain the. Interprofessional Team Leadership Framework

Insert table 5 here.

Facilitate shared leadership

For interprofessional teams to work effectively, each team member must accept responsibility as a member-leader stepping in and out of the leadership role when their professional expertise, particular knowledge of a client, or the situation comes to the fore (McCallin 1999, Wilson 2001).

This process requires a formal leader who has overall responsibility for the performance of the team, but consciously shares the leadership function facilitating joint decision-making, and delegates leadership roles (Day 1981, Sicotte, Amour & Moreault 2002, Ovretveit 1997, Mickan, Rodger 2000, McCallin 2003, Institute-for-innovation-and-improvement 2010, West et al. 2003).

The key mechanism for achieving this is empowerment (McCray 2003). The leader actively works to develop/maintain non-hierarchical, democratic structures (Ovretveit 1997, Krueger 1987). They coach team members (Maister 1993) to develop the skills required (McCallin 2003) share their ideas, work to create agreement and supply information the team requires (Mickan, Rodger 2000).

Transformation and Change

Transformational leadership is important (McCray 2003, Irizarry 1993, Gameau & Walter 1993). The IpTL acts as a role model in line with their espoused values (Pollard, Miers & Gilchrist 2005, West et al. 2014) in order to: create a climate in which staff are inspired (West et al. 2003) challenged, supported, motivated and rewarded (Irizarry, Gameau & Walter 1993); respond to change in a flexible way (Suter et al. 2007) and facilitate or act as a catalyst for practice change (Willumsen 2006).

Personal qualities

The IpTL must be able to show enthusiasm (Pollard, Miers & Gilchrist 2005), commitment (Abreu 1997), the ability to empathise (McCray 2003), and knowledge of people (Suter et al. 2007).

Goal alignment

The IpTL works to influence the direction and climate of the group to ensure goal alignment with the organization and productivity (Leathard, Cook 2004). They do this by ensuring the team has articulated a clear and inspiring vision of its work, creating regular times when it can review it's performance (Lyubovnikova et al. 2015) providing feedback to highlight important issues (Mickan, Rodger 2000, Leathard, Cook 2004).

Creativity & innovation

A productive balance of harmony and debate is vital to ensure creativity (Leathard, Cook 2004) and development of innovations and new practice models (Suter et al. 2007). However, teamwork processes and team leadership have been found to consistently predict team innovation (West et al. 2003).

Communication

The leader must facilitate the interaction processes, and develop/sustain clear communication channels in the team (Ovretveit 1997, Suter et al. 2007, Willumsen 2006, Blewett et al. 2010). They do this by initiating constructive debates and modelling their own ideas (Mickan, Rodger 2000, Lyubovnikova et al. 2015) and supporting, listening to and trusting team members (Mickan, Rodger 2000, Leathard, Cook 2004).

The leader must also manage conflict, ensuring a productive balance between harmony and healthy debate (Mickan, Rodger 2000, McCray 2003).

Teambuilding

Teamwork is not a naturally occurring phenomenon (Lyubovnikova et al. 2015). The team leader must therefore invest time in teambuilding, `setting expectations for working together (Suter et al. 2007) and creating a climate of mutual respect (Ovretveit 1997, Leathard, Cook 2004). They work to ensure cohesion (Willumsen 2006), developing the interpersonal skills of the team (Ovretveit 1997) promoting interprofessional collaboration through group reflection (McCallin 1999, Branowicki et al. 2001) on practice, and ensuring contextual socialization of new or inexperienced team members (McCray 2003).

Collaboration is promoted by allowing enough time for discussion and reflection on practice and encouraging staff to interact with those outside their profession (Suter et al. 2007, McCallin 2003, Branowicki et al. 2001).

Leadership clarity

Despite growing support for shared/collaborative/collective leadership models there is evidence to suggest that interprofessional teams need an overall team leader to operate effectively (McCallin 2003).

A 2009 study found that teams with a specific team leader had higher levels of staff satisfaction than teams where the leadership role was split (Nancarrow et al. 2009). Clarity of leadership is associated with clear team objectives, high levels of participation, commitment to excellence, and support for innovation (West et al. 2003). Primary healthcare team members rated their effectiveness more highly when they had strong leadership and high involvement amongst team members (Rosen, Callaly 2005).

Direction setting

The leader ensures that the team retains a focus on its priorities and goals, and that individual team members maintain the correct focus (Mickan, Rodger 2000). They work to manage team processes (Maister 1993) including setting clear tasks (Ross, Rink & Furne 2000) coordinating work (Mickan, Rodger 2000) and ensuring equitable allocation (Pollard, Miers & Gilchrist 2005).

External liaison

The team leader must exercise external responsibility for the team (Irizarry, Gameau & Walter 1993) ensuring that it is represented and gains the resources it requires (Maister 1993). This requires: promoting the work of the team (Irizarry, Gameau & Walter 1993) the ability to develop networks and linkages (Pollard, Miers & Gilchrist 2005) demonstrating effectiveness through data collection & evaluation (Irizarry, Gameau & Walter 1993) and adopting a marketing orientation to ensure the team understands its clients and can exploit new opportunities (Willumsen 2006).

Skill mix and diversity

The team leader's role is to ensure that the team contains the right skill mix and diversity to achieve its goals and tasks. This involves both external recruitment and internal development (Ross, Rink & Furne 2000) with regular supervision, annual performance reviews and access to relevant training important factors (Burton, Fisher & Green 2009).

Clinical and contextual expertise

Professionals will only be accepted into IpTL roles if they prove their professional expertise (Maister 1993, Irizarry, Gameau & Walter 1993, Branowicki et al. 2001). Knowledge of the professional role of others is also a key competency (MacDonald et al. 2010). Within this, it is important that the team leader balances focus between the needs of the patient, organisation and team (Branowicki et al. 2001). Understanding of the organisation's mission, structure, economics, politics (Branowicki et al. 2001) and current development programmes (West et al. 2014) together with a sound historical

perspective, are also important to facilitate understanding of context and ensure all perspectives are taken into account (Abreu 1997).

Discussion and conclusions

An IpTL framework in healthcare has been synthesised from the available published evidence and has been presented as a range of particular competencies that can be compared to the general management literature related to team management and leadership.

Many factors associated with better team leadership within management literature can also be seen in the IpTL framework. Both bodies of literature include a focus on: achieving organisational goals, managing performance, managing external relationships (boundary spanning activities) and demonstrating technical expertise (Larssen & LaFasto 1989, Hackman 1990, Stanniforth & West 1995, LaFasto & Larssen 2002, Hayes 2002, Hackman 2002, Katzenbach & Smith 2003, Shackleton 1995, Stoker 2008, Burke et al. 2006, Stoker 2008)

In contrast the IpTL framework specifically highlights a leadership function for the team and the review demonstrates that as well as maintaining the managerial function an interprofessional team requires a person who can promote transformation and change, and support creativity and innovation as key elements of their role. Significantly, a meta-analysis by Burke et al. (2006) shows that transformational leadership behaviours, (often linked to change and innovation) can have a potent effect within teams. West et al. (2003) also found that teamwork and team leadership processes consistently predict innovation.

Empowerment appears as a primary focus in the generic team leadership literature as a mechanism for collaboration, but the focus in the IpTL literature is more on shared, collaborative, or more recently collective (West et al. 2014) leadership. Conceptually these factors are distinct, but in the ways they are described appear to have more similarities. The IpTL literature talks more about shared, collective and collaborative leadership, particularly in relationship to professionals within the teams. However, there is a paradox in that there is good evidence that clarity of leadership (West et al. 2003, Nancarrow et al. 2009) also appears to be important. Other commentators clarify, that shared leadership in IpT's is facilitated by the team leader (Krueger 1987, Maister 1993). It may be that shared or collective leadership are more palatable concept to professionals than empowerment as they lend more status to professional expertise and accommodate autonomy rather than challenge it.

The IpTL framework overtly mentions team building as a key activity of the team leader and the wider literature on team leadership also refers to the fact that it takes effort to develop a team (Stanniforth and West 1995, Hackman 2002, Katzenbach and Smith 2003). In the IpT literature, teamwork is still often an ideal that health and social care organisations are working to attain and a level of complexity is apparently which is to do with ensuring the correct mix and level of skills in the team. The IpTL literature focuses on developing the dynamics within the team as a whole and increasing integrated professional practice, with less attention paid to setting priorities and managing performance.

The literature review also raised some general questions about IpT's. There is consensus in teamwork literature that teams become less effective as they become

larger. However, Nancarrow et al. (2009) found that larger interprofessional care teams providing intermediate and community care for older people produced better patient outcomes, despite less satisfaction amongst team members and higher intention to leave. It is not clear from these results whether there is a limit to this relationship, where the economies of scale and enhanced workforce flexibility delivered by larger services, becomes offset by the impact on teamworking? In a further study (Nancarrow et al 2013) comments on the difference between assumed shared decision making and shared power across professions and the reality; perhaps alluding to the challenges of working across a large multi-professional context.

A second issue is that whilst many of the services that took part in this particular study were called teams, it is unclear how many operate as teams in practice. As already discussed, 'team' is a term almost ubiquitously applied to work groups. Certainly, the size and structure of teams in this study are often outside the parameters put forward in the literature on teams. A final issue is the term interprofessional. There are increasing numbers of none professionally qualified staff in healthcare IpT's, however their role and function in the literature on interprofessional teamworking and leadership is totally absent. We would therefore propose that that interdisciplinary is a more suitable term to use as it is broader and inclusive of all team members.

What is different about IpTL in healthcare appears to be the unique context in which it is applied. The multiprofessional nature of the workforce in health, the public service setting, their function, and the contexts that they operate within, make the dynamics in healthcare IpT's differ from the dynamics of teams in other settings. This difference seems to be highlighted by West et al. (2014) who advocate collective, distributed

leadership practices for the NHS as a whole that resonate closely with the findings of this review.

Further, the literature does indicate that there are some elements of leadership practice, which may be particularly effective in interprofessional team settings. Perhaps the key issue highlighted is the fact that the operational workforce within health and social care is predominantly multi-professional in nature. Increasingly these professionals, together with other disciplines, are working together in a more integrated fashion. The creation of IpT's has therefore created a unique leadership context. Whereas traditionally professions would be functionally led (i.e. doctors by doctors, nurses by nurses) by a professional with recognised expertise, in IpT's this functional leadership divisions are impossible to sustain. The leader can at most be only from one profession or discipline and therefore cannot therefore demonstrate greater professional expertise in other professions. This makes IpT leadership more demanding as the team leader, needs to find a way of leading a diverse professional workforce, without being able rely on professional credibility as a locus of authority. Further, the IpTL needs to be able to find ways to persuade an interprofessional group, to give up some professional autonomy, to integrate their practices and operate as a team.

Conclusion

This critical literature review examines how leaders of interprofessional teams are functioning and the synthesis identifies a framework of factors that contribute to good leadership practice. With a continuing paucity of empirical research data on IpTL there is still much that is unknown about the IpTL process.

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Tables and captions

Table 1 – Databases Searched

DATABASE
ASSIA
CINAHL
Cochrane Database of Systematic Reviews
Health Management Information consortium
EMBASE
ERIC
MEDLINE
PsycINFO
NIHR
NHS Confederation
Department of Health
King's Fund
University of Sheffield, STAR library database

Table 2. – Key Search Terms for Interprofessional Team Leadership

Interdisciplinary OR interprofessional OR multiprofessional OR multidisciplinary OR Inter-disciplinary OR inter-professional OR co-operat* OR multi-professional OR multi-disciplinary OR "Inter disciplinary" OR "inter professional" OR "multi disciplinary" OR "multi professional"	AND	Team* [includes team, teams, team work, teamwork or team working]	AND	Lead* (includes Leads, Leading, Leader, Leadership)

Table 3. - Key search terms for outcomes of Interprofessional team leadership

Interdisciplinary OR interprofessional OR cooperat* OR collaborat* OR multidisciplinary OR Inter-disciplinary OR inter-professional OR co-operat* OR multi-disciplinary OR "Inter disciplinary" OR "inter professional" OR "multi disciplinary"	AND	team* [includes team, teams, team work, teamwork or team working]	AND	Lead* (includes Leads, Leading, Leader, Leadership)	AND	Length of Stay Patient Admission Patient Discharge Patient Readmission Patient Transfer Quality of Health Care Outcome and Process Assessment (Health Care) Outcome Assessment (Health Care) Treatment Outcome Treatment Failure Mortality Cause of Death Child Mortality Fatal Outcome Foetal Mortality Hospital Mortality Infant Mortality Maternal Mortality Perinatal Mortality Survival Rate

Table 4 - Quality Assessment Criteria

Screening questions				
1	**Problem statement**	Yes	Cannot tell	No
	Does the statement of the phenomenon lead directly to the purpose of the study and the research questions?			
2	**Purpose of the research**			
	Is the purpose of the research clearly expressed?			
3	**Research questions**			
	Are the research questions explicitly expressed?			
Detailed questions				
4	**Literature review**	Yes	Cannot tell	No
	Is the literature related to the research problem and point towards the research purpose?			
6	**Sampling and participants**			
	Is there description of type of sampling procedure?			
	Is there identification of inclusion criteria?			
	Does the sample size and configuration fit the purpose and sampling strategy?			
	Are features of the sample critical to the understanding of the findings described?			
	Do sites of recruitment fit the evolving needs of the study?			
7	**Data gathering strategies**			
	Is there clear description of data gathering procedures?			
	Is there discussion of time frame of data gathering?			
8	**Data management and analysis strategies**			
	Are methods used described?			

	Is there identification of categories or common elements found?			
9	**Findings**			
	Are interpretations of data demonstrably plausible and/or sufficiently substantiated with data?			
	Are concepts or ideas well-developed and linked to each other?			
	Are concepts used precisely?			
	Is there provision of evidence as to how representative in the sample the various findings were?			
10	**Conclusions, discussion, implications, suggestions for future study**			
	Does the discussion pertain to all significant findings?			
	Do the interpretive statements correspond to the findings?			
	Are the study findings linked to the findings of other studies, or to other relevant literatures?			
11	**Validity**			
	Is there evidence that researcher has considered the effect of his/her presence on the research findings?			
	Is there evidence that researcher has considered possibility of research bias or misinterpretation?			
	Are validation techniques used that fit the purpose, methods, sample, data and findings of the study?			

Table 5. Interprofessional Team Leadership (IPTL) Framework

Facilitate Shared leadership • Consciously involve team members in, decision making and delegate responsibilities appropriately (Day 1981, McCallin 1999, Wilson 2001,Ovretveit 1997, Mickan, Rodger 2000, McCallin 2003, Institute-for-innovation-and-improvement 2010, Sicotte et al 2002, West et al. 2003). • Empower team members (Mcray 2003) • Develop and maintain non-hierarchical structures (Ovretveit 1997, Krueger 1987) • Provide information the team requires (Mickan & Rodger 2000) • Work to create agreement (Mickan & Rodger 2000) • Coach colleagues in shared leadership (McCallin 2003, Maister 1993)
Transformation and Change (McCray 2003, Irizarry 1993, Gameau & Walter 1993) • Create a climate where staff are challenged, supported, motivated and rewarded (West et al. 2003) • Respond to change flexibly (Suter et al. 2007) • Facilitate or act as a catalyst for practice change (Willumsen 2006). • Act as a role model (Pollard, Miers & Gilchrist 2005, West et al. 2014) • Inspire other team members (West et al. 2003)
Personal qualities • Enthusiasm (Pollard, Miers & Gilchrist 2005) • Commitment (Abreu 1997) • Empathy (Mcray 2003) • Knowledge of people (Suter et al. 2007)
Goal alignment • Ensure the team has articulated a clear and inspiring vision of its work (Lyubovnikova et al. 2015) • Assure productivity and goals are in line with the organization (Leathard, Cook 2004) • Protect regular time for the team to review its performance (Lyubovnikova et al. 2015) • Provide feedback about important issues (Mickan, Rodger 2000, Leathard, Cook 2004)
Creativity & innovation • Establish a productive balance of harmony and debate to ensure creativity (Leathard, Cook 2004) • Develop innovations and new practice models (Suter et al. 2007) • Ensure effective leadership and team work processess (West et al. 2003)

Communication • Maintain clear communication channels and facilitate interaction processes (Ovretveit 1997, Suter et al. 2007, Willumsen 2006, Blewett et al. 2010) • Listen to, support and trust team members (Mickan, Rodger 2000, Leathard, Cook 2004) • Initiate constructive debates and share their own ideas (Mickan, Rodger 2000, Lyubovnikova et al. 2015) • Manage conflict and maintain a productive balance between harmony and healthy debate (Mickan, Rodger 2000, Mcray 2003)
Teambuilding • Set expectations for working together (Suter et al. 2007) • Create a climate of mutual respect (Ovretveit 1997, Leathard, Cook 2004) • Ensure cohesion (Willumsen 2006) • Develop the interpersonal skills of the team (Ovretveit 1997) • Ensure the contextual socialization of new/inexperienced team members (Mcray 2003). • Promote interprofessional collaboration (Suter et al. 2007, McCallin 2003, Branowicki et al. 2001) • Facilitate group reflection on practice (McCallin 1999, Branowicki et al. 2001)
Leadership clarity • Esnure clarity of leadership (Nancarrow et al. 2009, West et al. 2003) • Combine strong leadership and high involvement (Rosen, Callaly 2005)
Direction setting • Coordinate tasks (Mickan, Rodger 2000) • Manage Processes (Maister 1993) • Ensure work is allocated work equally (Pollard, Miers & Gilchrist 2005) • Set clear tasks (Ross, Rink & Furne 2000)
External liaison • Represent the team externally (Irizarry, Gameau & Walter 1993) • Ensure necessary resources (Maister 1993) • Develop strategies for promoting the work of the team (Irizarry, Gameau & Walter 1993) • Demonstrate effectiveness through data collection & evaluation (Irizarry, Gameau & Walter 1993) • Ensure the team understands its customers and can exploit new opportunities (Willumsen 2006). • Develop networks and linkages(Pollard, Miers & Gilchrist 2005)
Skill mix and diversity • Recruit externally and develop internally (Ross, Rink & Furne 2000) • Ensure regular Supervision and PDR (Burton, Fisher & Green 2009). • Assure access to relevant training (Burton, Fisher & Green 2009).
Clinical and contextual expertise • High levels of professional expertise (Maister 1993, Irizarry, Gameau & Walter 1993, Branowicki et al. 2001) • Demonstrate in-depth understanding of the organisation (Branowicki et al. 2001) and current development programmes (West et al. 2014) • Balance focus between the needs of the patient, organisation and team (Branowicki et al., 2001) • Facilitate understanding of context and ensure all perspectives are taken into account (Abreu 1997) • Knowledge of the professional role of others (MacDonald et al. 2010)