NHS Improvement

Phase 2: Design

Culture and Leadership Programme Phase 2

VERSION 1
SEPTEMBER 2017

The Kings Fund

Center for Creative Leadership

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

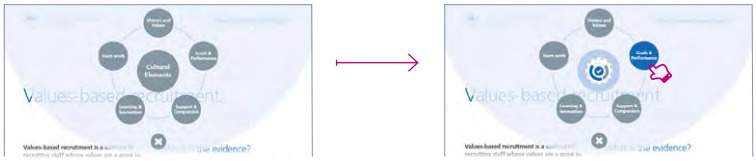
Essential reading: how to use this document

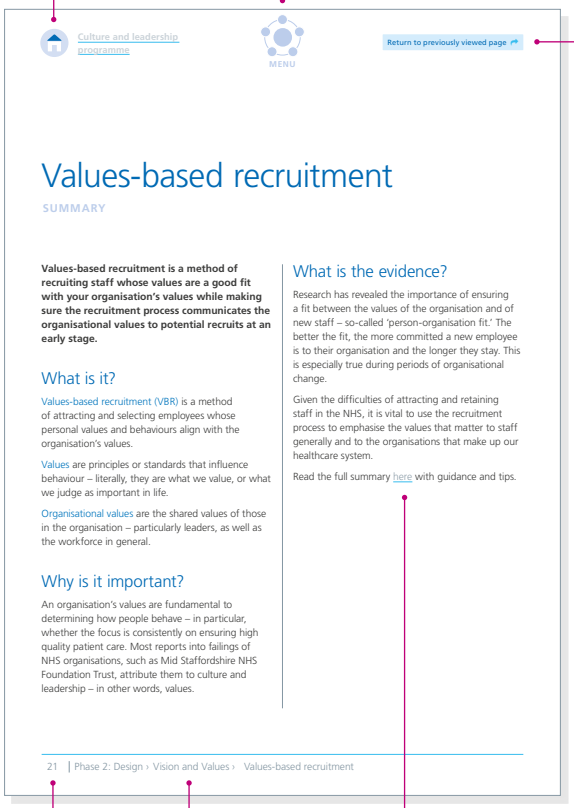
This document has been set up to help you find your way around. Some aspects are interactive and can help you 'jump' around the toolkit. To make full use of these features please download the toolkit and access it through a PDF viewer.

The diagram below shows the interactive features you'll find in Sections 1–4 of the document.

Home button
Clicking this will take you back to the main contents page

Interactive Menu
Clicking this will open a menu that jumps between chapter pages.



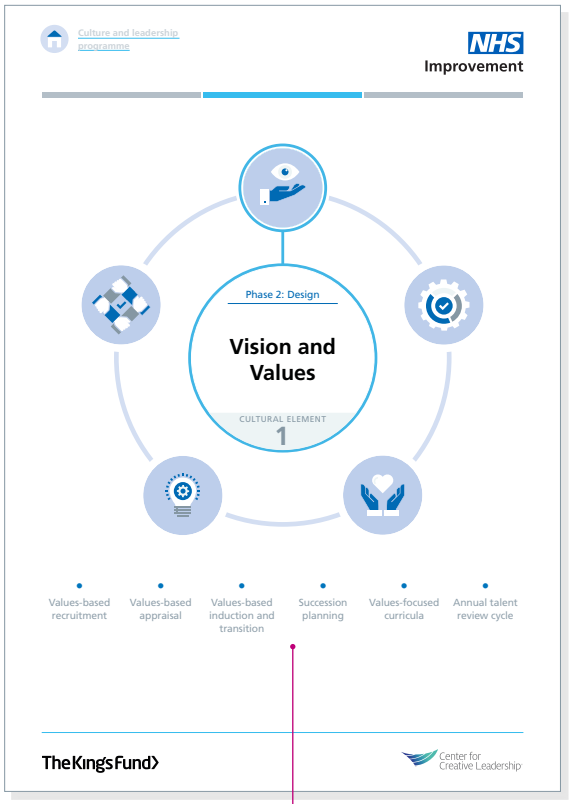


Return button
Clicking this will take you back to the last page you viewed, even if you jumped there from another section

Page number

Chapter heading
Click to go to chapter contents

Hyperlinks
There are hyperlinks throughout the document which can take you to other sections or external resources*



Chapter contents
Clicking the headings will take you to the first page of that section

** You must have an internet connection*

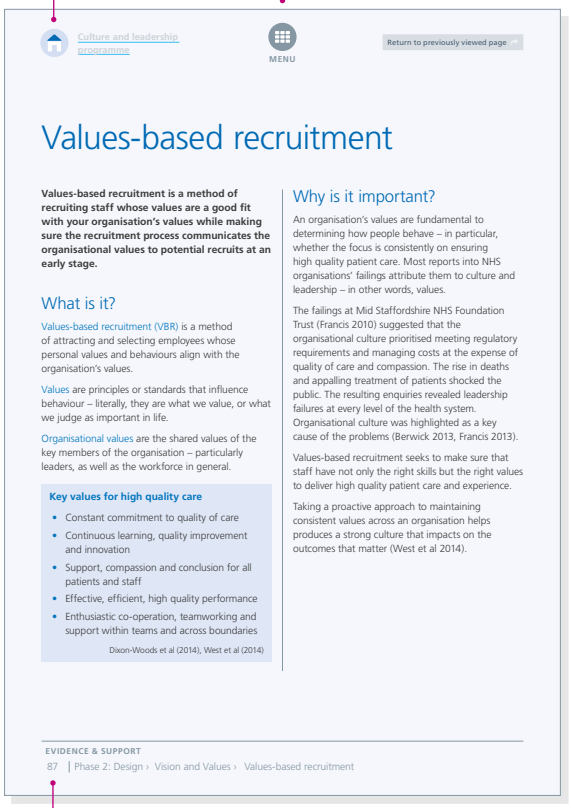
Essential reading: how to use this document

In addition to the general interactive elements, the Evidence and support section has it's own menu page. You can access this throughout the section and you jump to specific information.

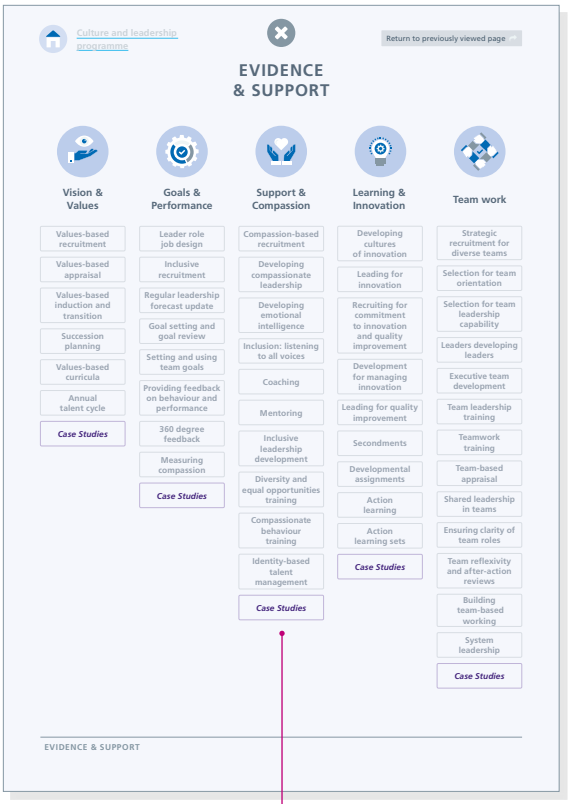
Home button
Clicking this will take you back to the main contents page

Interactive menu
Clicking this will open a menu that jumps between chapter pages

Close menu
Clicking this will take you back to the previous page you were viewing



Page number



Section headings
Clicking the buttons will take you to the first page of section

NHS Improvement

Acknowledgements

NHS Improvement, The King's Fund and Center for Creative Leadership would like to thank the teams from our three pilot trusts, Central Manchester University Hospitals NHS Foundation Trust, East London NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust for their time, creativity and commitment in shaping the resources presented here. Your contributions have again significantly advanced this work. We would also like to thank the following colleagues for their generosity in sharing their learning of working through phase 2 (design) having utilised earlier versions of the phase 1 (diagnose) tools:

- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust,
- Lancashire Care NHS Foundation Trust, and
- Derby Teaching Hospitals NHS Foundation Trust

We would also like to thank all of the individuals and organisations who have contributed case studies and useful resources and especially the NHS Leadership Academy, NHS Employers and Do OD.

Finally thank you to everyone who is contributing to the community of practice, for sharing their experiences of culture change.

The King's Fund and CCL were commissioned by NHS Improvement to provide the evidence base for the programme based on their years of research in this field and the work on the earlier iterations of the collective leadership toolkit.

About The Kings Fund

The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; support individuals, teams and organisations to lead change in order to improve care; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

www.kingsfund.org.uk @thekingsfund

Other useful information

Developing People – Improving Care

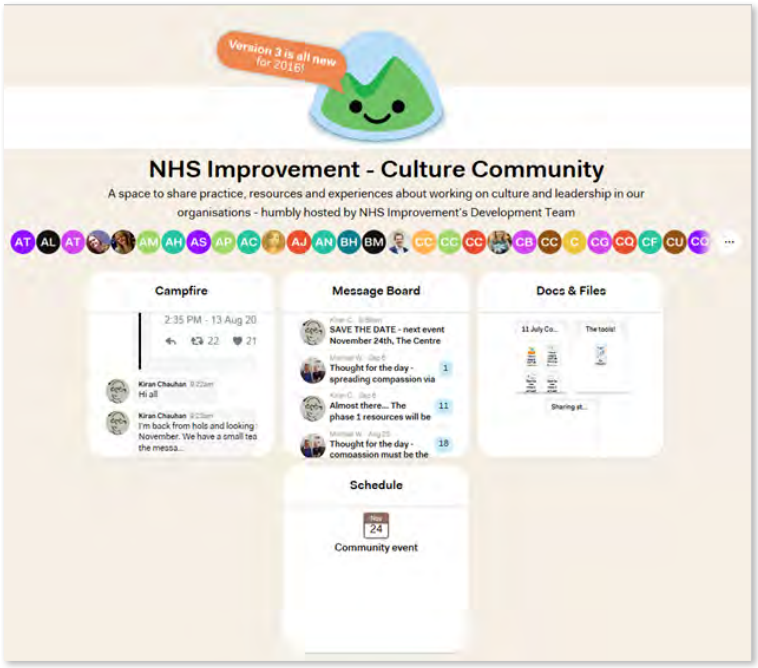
Developing People – Improving Care is the national framework to develop leadership and improvement capacity, which will equip and encourage all people in NHS funded roles to continually improve local health and care systems, delivering improvements in population health, patient care and value for money.

You can read more about it here.

Join our community

We have a thriving and growing culture community of practice – come and join us!

If you would like to get involved, please contact: nhsi.culture@nhs.net



Stay up to date at:

https://improvement.nhs.uk/resources/culture-and-leadership/

www.kingsfund.org.uk/projects/changing-culture-collective-leadership

If your trust is starting work on organisational culture and you are looking for support, we will be establishing action learning sets to help bring together colleagues involved in this area.

If this is of interest to you please contact nhsi.culture@nhs.net

Finally, as trusts develop their approach to culture, we are keen to hear about examples of good practice. If you have a case study or materials you would be willing to share, please contact: nhsi.culture@nhs.net

NHS Improvement

Content overview

This work is designed to be an interactive PDF that enables you to access the resources you require quickly, and without having to read the entire document.

Section 1 includes this introduction, with an overview of the key concepts.

Section 2 describes the process of developing a leadership strategy. This brings together advice from the pilot trusts and sample strategies, along with some theoretical approaches. It also gives an example of a workshop run by a trust at the end of its Phase 2 journey.

Section 3 comprises the main body of the resource. It is divided into five cultural elements. These five elements are explained in more detail in key concepts below.

The five cultural elements

1. Vision and values
2. Goals and performance
3. Support and compassion
4. Teamwork
5. Learning and innovation

For each of these, you will find a range of resources focusing on different approaches or activities that are evidence of changing organisational culture, including:

- topic summaries
- context explaining why the topic is important
- details of the supporting evidence
- guidance on 'how to do it': moving from theory to practice
- resources, tools and links
- case studies.

Seeking further case studies

As trusts develop their approaches to culture, we are keen to share examples of good practice. If you have a case study or materials you would be willing to share, please contact: NHSI.culture@nhs.net

Section 4 looks ahead to *Phase 3: Delivery*. This final resource of the series supports trusts to implement their leadership strategy: the key to delivering high quality, continuously improving compassionate, inclusive patient care. This will be published during 2018.

NHS Improvement

Contents

Support and compassion

Learning and innovation

Team work

Conclusion

Evidence and support

Vision and values

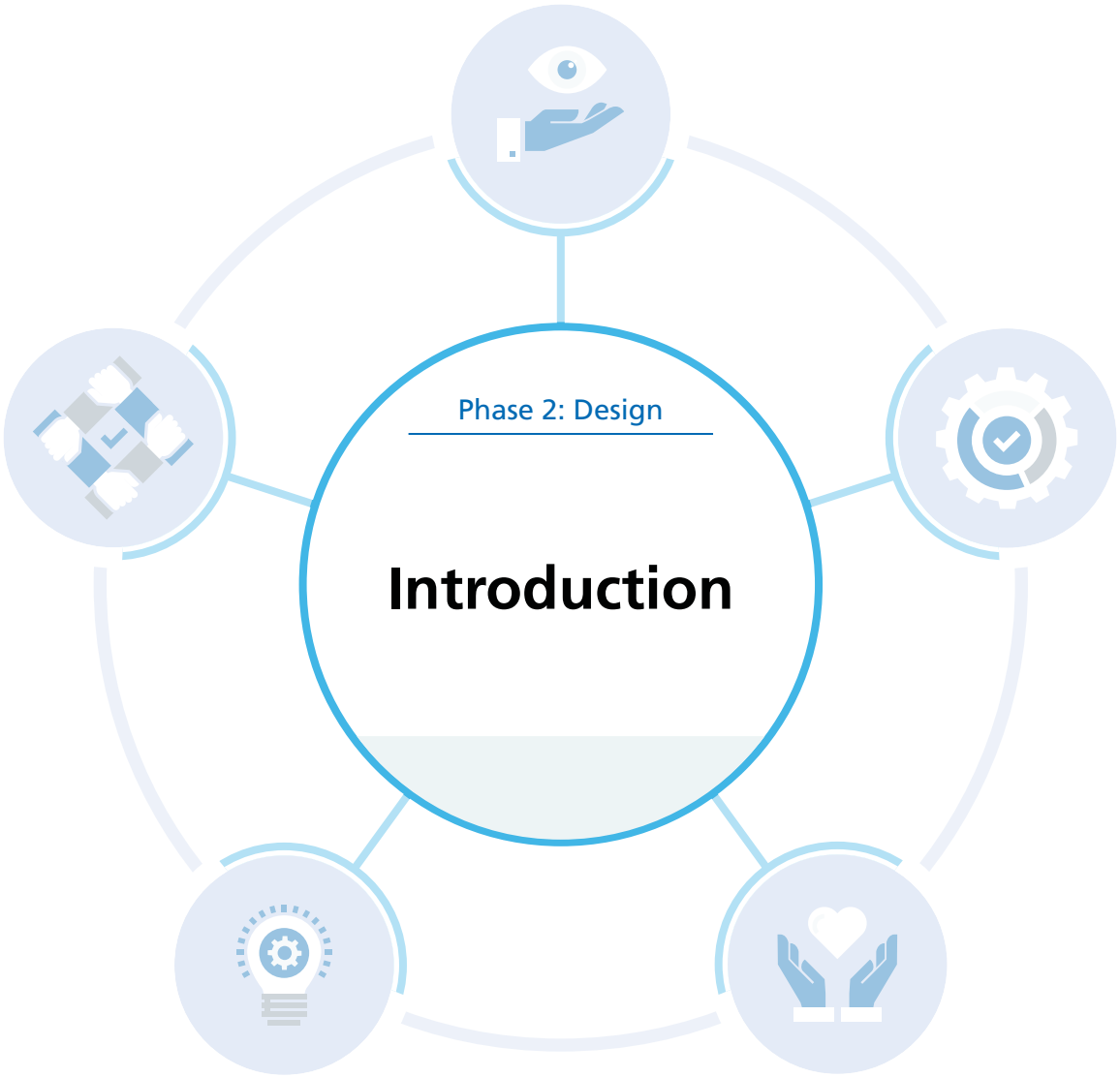
Goals and performance

Support and compassion

Learning and innovation

Team work

NHS Improvement



Phase 2: Design

Introduction

The Kings Fund

Center for Creative Leadership

Introduction

Welcome to the Culture and Leadership programme - Phase 2: Design. This is the second in a series of three resources designed to help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality and compassionate care.

Culture matters

Leadership, particularly compassionate inclusive leadership, is the key to enabling cultural change so that NHS organisations can:

- deliver high quality care, value for money and support a healthy and engaged workforce.
- enable staff to show compassion, to speak up, and to continuously improve and create an environment where there is no bullying and where there is learning.
- help boards assure their governance in the 'culture and capability' domain of the well-led framework and improve their results.

Following this programme will help you to create a strategy to develop your organisation's culture and leadership.

How to use this resource

Before you use this resource, we recommend you complete Phase 1: Discover or review information you already have against the five cultural elements.

The culture and leadership programme: the three phases

This resource aims to help you develop your compassionate, inclusive leadership strategy based on the outputs from Phase 1. The strategy should fit in with your trust approach to organisational and workforce development. It will influence your future organisational design, including the make-up of your workforce and the structures and processes you use.

Tip: This resource includes more than 50 evidence based interventions, and you will not want to adopt all of them in your trust. Select those that best reflect the outputs from Phase 1. Then set your priorities based on what is most important to your trust right now and what resources you have access to.

How it was developed

The series was developed by NHS Improvement in partnership with The King's Fund, the Center for Creative Leadership and three pilot trusts: Central Manchester University Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and East London NHS Foundation Trust. It draws on national and international evidence of the elements and behaviours needed for high quality care cultures. It highlights important links and powerful synchronicity between compassionate, inclusive leadership values, the core cultural values of high-performing healthcare organisations and the key elements that are needed to nurture a culture of innovation.

Key concepts

The resource describes a wide range of different interventions. However they are underpinned by common principles, such as:

- compassion
- compassionate, inclusive leadership
- the five cultural elements.

Each of these principles is described below.

Compassion

Compassion has been described as having four components (Atkins and Parker 2012):

- attending
- understanding
- empathising
- helping.

In an interaction between a leader and their team, compassionate, inclusive leadership means:

- attending – paying attention to staff; 'listening with fascination'
- understanding – finding a shared understanding of the situation they face
- empathising – felt relation with another's feelings
- helping – taking intelligent action to help

When the concept of compassion is misunderstood, it can be seen as a 'soft' option and lacking a focus on outcomes. However, demonstrating compassion genuinely and consistently requires self-awareness and discipline. It is an active rather than passive approach, and the resulting actions can enhance effective performance management.

Compassionate, inclusive leadership

Leadership is the most powerful influence on an organisation's culture. To nurture a culture of compassion in their organisation, leaders need to embody compassion in their leadership. Supportive leadership and quality of care in the NHS are clearly linked. (Shipton et al 2008).

Cultures that support high quality care display compassionate, inclusive leadership. They are cultures where staff at all levels are empowered, both as individuals and in teams, to act to improve care within and across trusts (leadership of all, by all and for all).

NHS leaders need to demonstrate the four compassionate behaviours described above through their leadership of healthcare organisations, at every level (*Caring to change*, West and Chowla 2017).

The elements of compassionate, inclusive leadership are:

- everyone taking responsibility for ensuring high quality, continually improving and compassionate care

- shared, rather than dominating, leadership in teams
- continual development of teamworking (West 2012)
- interdependent leadership, with leaders working together across boundaries, prioritising patient care overall – not only in their area of responsibility
- a consistent approach to leadership across organisations characterised by authenticity, openness, curiosity, kindness, appreciation and, above all, compassion (West et al 2014a).

Research into cultures of high quality care internationally suggests that dominant, hierarchical, top-down approaches to leadership are the least effective ways of managing healthcare organisations (West et al 2014b).

Tip: Leadership Terminology

The NHS organisations featured in this resource use differing language to describe their approach to leadership. Some describe it as 'compassionate', while others describe it as 'collective' or even 'distributed'. These terms all have their own definitions, what matters is the fundamental values that they have in common.

The five cultural elements

Culture is defined by the values that we live by every day. These may not be the same as the stated values, the lived values can be seen by how people actually behave: 'the way we do things around here'.

Evidence shows that there are five key elements in high quality care cultures. These are closely aligned with the values in the NHS Constitution.

Cultural Elements	Values	The way we do things
Vision and values	Constant commitment to quality of care	Everyone taking responsibility in their work for living a shared vision and embodying shared values
Goals and performance	Effective, efficient, high quality performance	Everyone ensuring that there are clear priorities and objectives at every level and intelligent data constantly informing all about performance
Support and compassion	Support, compassion and inclusion for all patients and staff	Everyone making sure all interactions involve careful attention, empathy and intent to take intelligent helping action
Learning and innovation	Continuous learning, quality improvement and innovation	Everyone taking responsibility for improving quality, learning and developing better ways of doing things
Teamwork	Enthusiastic cooperation, team working and support within and across organisations	Everyone taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

Fig 1: Cultural Elements

The next section describes the activities that our pilot trusts and other organisations have undertaken in starting to develop their leadership strategies.

NHS Improvement

Phase 2: Design

Building your strategy

Using the programme to design your leadership strategy

NHS organisations invest a great deal of time and resource in creating strategies, describing their clinical, financial, estates, partnership and other ambitions, but few have leadership strategies.

> "While every leader is aware of the value of a well-defined business strategy, few… give thought to the leadership that will be required to implement strategies."
>
> *Pasmore (2014)*

This section explains why it is so important for NHS organisations to have an explicit leadership strategy, and shows how to do it.

What is a leadership strategy?

A leadership strategy describes the leadership culture needed to nurture the overall organisational culture. It identifies the leadership skills and behaviours required. It plans how to identify, attract, develop and sustain leadership and how to ensure the diversity of leaders needed to implement and sustain the desired culture.

A leadership strategy is based on the organisation's strategy and has two overarching purposes:

- to identify what kind of leadership the organisation needs to achieve its strategic goals
- to ensure this kind of leadership is developed, practised and maintained.

Why is it important?

Even the best and boldest strategies die on the vine unless leaders are equipped not only with technical skills, but the ability to create a culture in which continuously improving, inclusive and compassionate care can be delivered.

The challenges that face healthcare organisations are too great, and too many, for leadership to be left to chance or to piecemeal approaches. If healthcare organisations are to face the future confidently and deliver high quality, compassionate care, they need to develop and implement leadership strategies that will produce the cultures they need to fulfil their objectives.

- Leadership development should be collective, focused on leadership as a whole, not just on individuals. This is because it needs to change the culture, not simply individual leaders' capabilities. Individual leaders make a difference in terms of organisational performance. But it is the co-ordinated action of the leadership as a whole that determines organisational effectiveness and success in adapting to the pressures and change in delivering health and care. Compassionate inclusive leadership is core to this.
- The leadership development strategy will have major implications for talent management processes. You need to make sure your talent management systems, processes and policies are aligned with the leadership development strategy and the leadership strategy overall.

This will ensure that together they integrate to reinforce the organisation's values and vision.

Tip: The leadership development plan

Once you have a vision of what you expect from your leadership, you need to describe how it will be achieved, in a complementary plan describing the actions needed to achieve the vision, working with current and future leaders.

Learning from trusts

- A leadership strategy will inevitably draw on and complement many other strategy development cycles already underway in your organisation. It will depend on the success of other plans and vice versa. But even strategies that seem to be clearly focused on leadership will start at different stages of knowledge, sophistication, speed and development.
- One trust emphasised the importance of linking this work to established quality improvement projects in the organisation to ensure learning was transferred.
- Be realistic about the level of connection and any strains between the people/ leadership strategy and other organisational strategies.

Using the Culture and Leadership Programme

Phase 1: Discover involves collecting information about the strategy, vision, mission, future challenges, political context, threats and opportunities that the organisation faces. Carrying out this phase will have enabled you to identify the leadership capabilities you will need in the future and the gap between them and current capabilities.

There are many ways of organising the intelligence from Phase 1. The link (Annex A) takes you to a table adapted from the Center for Creative Leadership document (CCL 2014), suggesting one way of making sense of the information.

Learning from trusts

The Culture and Leadership Programme was tested by three pilot trusts: Northumbria Healthcare NHS Foundation Trust, East London NHS Foundation Trust and Central Manchester University Hospitals NHS Foundation Trust. Others used selected parts of Phase 1 and provided valuable insights into using the following six diagnostic tools (described in Phase 1):

- culture and outcomes dashboard
- board interviews
- leadership behaviour surveys
- culture focus groups
- leadership workforce analysis
- patient experience.

At the end of Phase 1 the diagnostic data and intelligence provided a wealth of insights, shedding light on their organisations' future leadership needs. This included better understanding of areas of strength and of the organisation's current potential to develop a culture of collective leadership.

A key lesson was not to underestimate the value to the organisation of the evidence-based data that would flow from the diagnostic tools. Trusts that used the resource were positive about the benefits of using some or all of these diagnostic tools. They felt they gave weight to their presentations to senior leaders. East London NHS Foundation Trust described it as 'building the will in the organisation'.

Synthesis workshops proved to be an effective way of making sense of, and sharing the learning with stakeholders.

Another lesson was to be prepared to return to the diagnostic phase again and again. 'Diagnostics' is never over – it is a crucial input that needs to be repeated during the next strategic phases.

The importance of bringing organisational development and transformation/quality improvement leads together to work on the programme cannot be underestimated. In Manchester these teams are working jointly on the production of the leadership strategy.

The Manchester team intends to make the 'diagnosis' described in Phase 1 an ongoing activity. The organisation recognises the data's value, and is looking to establish a continuous process of in-depth

diagnostics. This will take place while it makes predictions about its future needs and direction.

This means that their strategy has to be a live entity, broad enough to incorporate new insights as they emerge. Their path is therefore more of a zigzag than a straight line.

Developing the leadership strategy: step by step

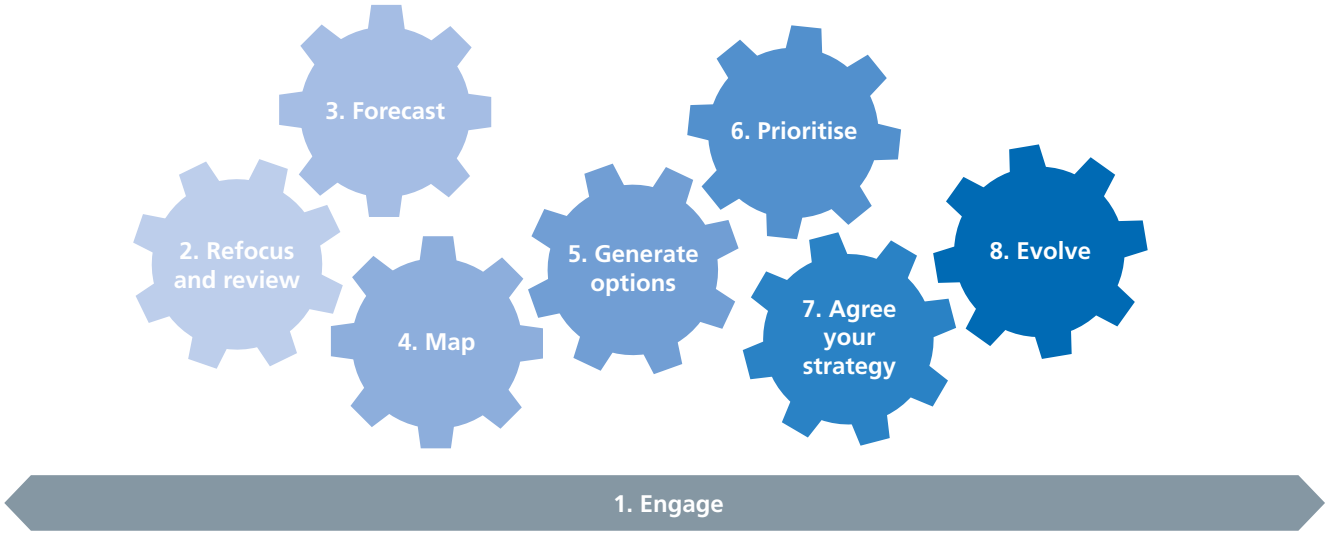
The end of Phase 1 forms a natural pause and an opportunity for reflection. By this point, users should have built robust teams, and developed rich pictures of their organisations' leadership strengths and developmental needs. Trust-wide conversations during Phase 1 create momentum and act as interventions in themselves, shifting beliefs and values about leadership in the organisation.

The aim of Phase 2: Design is to help trusts develop a collective leadership strategy based on Phase 1's outputs.

This section describes steps that will increase your chance of success in developing a leadership strategy, drawing on shared learning. Some are drawn from NHS Improvement's Strategy Development Toolkit. These activities will help as you start the design phase of your organisation's culture work.

Note that describing strategy development as a sequence of steps implies that the process is linear. All too often it is not. The diagram below represents how the steps may interact.

Strategy development steps



Step 1: Engage

Continuous engagement underpins any successful strategy. Strategy developed by the whole organisation will contain more insight, and will have been challenged more thoroughly by those closest to the situation on the ground. Implementation will be more effective, and staff involved in creating the strategy are more likely to support it.

How far, and in what ways, you should involve different staff groups will depend on which stage you are at. For example, during the 'discover' stage, change teams did most of the work and most engagement took the form of explaining the process, sharing emerging analysis and asking for help to interpret it. At other stages, such as 'generate options', the whole organisation needs to be drawn in, and offered opportunities to suggest and debate ideas for change.

Step 2: Refocus and review

Share Phase 1's outcomes and the subsequent steps with the organisation, discussing what these mean for them.

Then revisit your organisation's purpose and objectives, which you identified at the beginning of Phase 1. Has your organisation's context shifted? Check that your assumptions about changes in the environment align with the board's.

As part of working through the implementation plan for the strategy you need to think about whether the organisation is ready for the change in order to maximise the impact of the proposed interventions and to move to a culture of collective leadership.

Pettigrew and Whipp (1991) describe three dimensions of change: content, process and context. They emphasise the continuous interplay between the change dimensions. Successful change is a result of the interaction between the content or 'what' of change (objective, purpose and goals) the process or 'how' of change (implementation) and the organisational context or 'where' of change (the internal and external environment.

Be realistic about the extent of any changes: they may indicate that you should investigate further before starting to design your leadership strategy. Assessing the readiness for change will involve further discussions with a diverse set of stakeholders including transformation teams, clinicians and front line staff. The NHS change model is helpful in considering this: http://theedge.nhsiq.nhs.uk/wp-content/uploads/2015/10/nhs_change_model_july2013.pdf

As part of this step, review and re-contract with your change team (Phase 1 toolkit) and executive sponsors (Phase 1 toolkit). For example, consider what has worked well, and what needs to be different? Do you need to adapt to a change of team members? Are new skills needed as you move into Phase 2: Design? Are oversight arrangements (for example, to an executive team or steering committee) still ready for the next phase?

Step 3: Forecast your leadership needs

Forecasting is very context-specific, but for most organisations this means identifying and estimating the impact of internal and external drivers.

Identify the clinical services and other strategies that need a strengthened leadership support system. Are there enough people with the skills, motivation and appropriate styles in the leadership pipeline to deliver them?

Describe your future leadership needs, building on the information you obtained in Phase 1, and paying attention to the findings of the leadership workforce analysis diagnostic tool.

Tip: The big picture and the detail

Some organisations used this step to consider the 'big picture', including new health and care footprints, while others spent time thinking about future leadership numbers, grades and roles, depending on their context and external drivers.

Learning from trusts

Manchester's forecasting activity focused on the quantity, quality and capability of its leaders. They set out to map the whole organisation using the leadership workforce analysis diagnostic tool, but that proved complicated and time-consuming. However, it did prove useful in highlighting gaps in the trust's ability to predict future needs, and indicated shortcomings in their workforce planning. The trust intends to repeat the exercise, using the same diagnostic tool, but only to the executive team and the two levels below. In this way, they will gain an understanding of the skills and attributes needed for the new roles after their merger with University Hospitals of South Manchester.

Step 4: Map your current state against your goals

The purpose of mapping is to understand the extent to which your organisation's current interventions add value to leadership in relation to each of the five cultural elements. Ideally, the change team should carry out the mapping to identify what you need to do in future to develop the leadership and culture that your organisation needs.

To do this, you will need to:

- be clear about the purpose of your organisation's current interventions, which cultural element they are targeting and the targeted outcome for an intervention (focusing on explicit key purpose)
- develop an overview of what is currently done and what needs to be done for each cultural element, in terms of regular activities, feedback loops and improvement activities
- understand which are the most important elements to focus on in a strategic change to create a culture of collective leadership.

This link (Annex B) takes you to an exercise to map current interventions against the five cultural elements and plan future interventions, undertaken by University Hospitals South Manchester and Central Manchester University Hospitals NHS Foundation Trusts.

The second link describes Northumbria's mapping exercise(Annex C).

Building on Phase 1: Discover, the mapping exercise helps develop an overview of future activities in line with the organisation's leadership needs and overall strategy. This overview of future activities includes:

- maintaining existing interventions
- modifying existing interventions
- ceasing existing interventions
- initiating new interventions.

Step 5: Generate options for investing in leadership development

Having completed the mapping exercise, revisit the board report that you produced at the end of Phase 1 to generate options. Involve everyone in producing ideas to address the issues identified in the report. Draw your ideas and inspiration for improving the organisation's leadership from as wide a range of sources as possible. Failing to do this will result in a weaker strategy.

Current good practice in the NHS offers excellent ideas for change and Section 3 of Phase 2: Design includes a wide range of resources, evidence and case studies that can inform your strategic initiatives.

Learning from trusts

- Generate options when it feels most appropriate to your team. This could be earlier than you expect. Prepare to address the fact that once you have engaged staff in Phase 1 and asked for their ideas, they could justifiably expect quick action.
- East London NHS Foundation Trust uses option generation and prioritising activities to ensure that the investments it is already making are aligned with its leadership plan. As a result, it is getting best value for money from its current investment, which represents a substantial resource commitment by the trust.

Step 6: Prioritise your investment

Scrutinise the options generated in terms of how far they achieve your goals, addressing the gaps and building on strengths revealed through Phase 1: Discover.

Choose which strategic initiatives to pursue and build them into a coherent strategy. These initiatives should create a strategy that combines high quality care for patients with financial viability, resulting in sustainable clinical services. Identify the courses of action to pursue, and build them into a coherent strategy.

Balance each option's potential for most impact with its resource requirement.

Learning from trusts

Following Phase 1: Discovery, East London NHS Foundation Trust ran two workshops for 40 staff across the organisation, including senior leaders. The aim was to identify what activities were already happening for each of the cultural elements (including leadership development activities) and to build on what was going well while identifying areas for improvement.

From this mapping process, the trust identified and prioritised one theme or activity they wanted to work on against the five cultural elements. They took a strengths-based approach, choosing areas where staff were reporting successes, and decided to build on them, noting that the trust's culture at ELFT is not one of standardisation; it is about creating the environment for people to flourish.

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) were users of an earlier version of the Phase 1 tools, and this link (Annex D) takes you to a description of a workshop they ran towards the end of phase 2 as they were about to finalise their leadership strategy.

Step 7: Agree your leadership strategy

Create and publicise the strategy and implementation plan, and allocate resources to deliver them. Set out the activities, milestones, measurements and key performance indicators, being clear about who will deliver what, by when.

Step 8: Evolve

The strategy implementation process and key outcomes need to be evaluated at every step. The collective leadership strategy must be integrated with the organisational development strategy. Steps and milestones must be specified before the collective leadership structure, culture and capabilities can be fully created. Now is the time to identify gaps in resources or systems – and to take action to fill them.

Sample strategies

Here are some strategies developed by other trusts who have worked with The King's Fund before NHS Improvement released Phase 1 of the Culture and Leadership Programme.

Lancashire Care NHS Foundation Trust

People Plan

Derby Teaching Hospitals NHS Foundation Trust

People Strategy

Central Manchester and University Hospitals South Manchester NHS Foundation Trust

This is an excerpt from the OD plan being proposed in Manchester to achieve a successful merger

Resource

See also NHS Improvement's Strategy Development Toolkit

Evaluation

At the end of this phase, you will want to evaluate the effectiveness of the strategy design process you have just undertaken and capture the lessons learned. You will want to think about how you will measure whether your culture and leadership programme has achieved its objectives, once it is implemented.

During Phase 2 – Design, the culture and leadership programme will have become better known outside the change team, so we recommend you evaluate this phase with the internal change team and other staff and stakeholders.

To capture lessons learned and information about the effectiveness of your design phase, you can:

- conduct lessons learned interviews or focus groups to identify the design process's impact on staff
- review the leadership behaviours reflection questionnaire (tool G2) and discuss any changes in the teamworking assessments (tool G3) during the phase
- review the process you followed against the activities, milestones, measurements and key performance you set out to achieve.

Remember that culture change takes time, and evaluation is an ongoing, continuous process.

In Phase 1 - Discover, you identified a baseline that you can review annually. To monitor the impact on culture and outcomes, you can use the culture and outcomes dashboard.

Moving on to Phase 3

Having developed your leadership strategy and implementation plan, Phase 3 will be about implementing them and evaluating their impact. The delivery phase involves individual leadership development and organisational development, targeting culture, systems and processes, as well as leadership development in an integrated and strategic way.

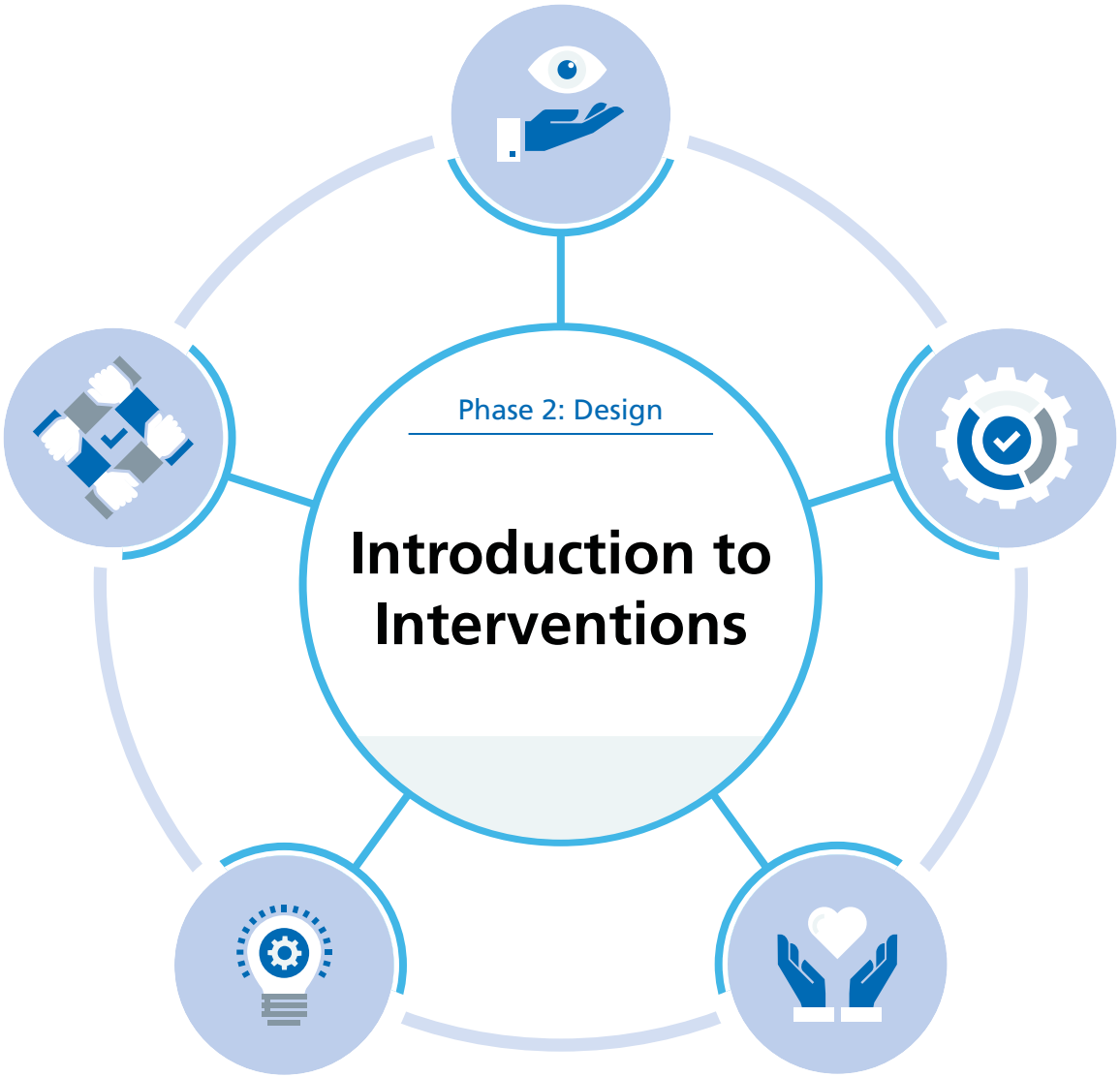
It is important to monitor delivery to ensure the strategy is being implemented and is effective. This will involve re-evaluating the strategy regularly, or when unexpected changes occur, recommitting to the existing direction, and refreshing or recreating it if necessary.

References

Pasmore W (2014). Developing a leadership strategy. A critical ingredient for organisational success. Center for Creative Leadership, San Francisco CA

Pettigrew A, Whipp R (1991) Managing change for competitive success. Blackwell, Oxford

NHS Improvement



Phase 2: Design

Introduction to Interventions

The Kings Fund

Center for Creative Leadership

Interventions to support the development of your leadership strategy

This section contains summaries of the interventions identified through research and collated by Professor Michael West and The King's Fund and to which colleagues from our three pilot trusts have contributed.

It consists of links that take you to the five cultural elements:

The cultural elements

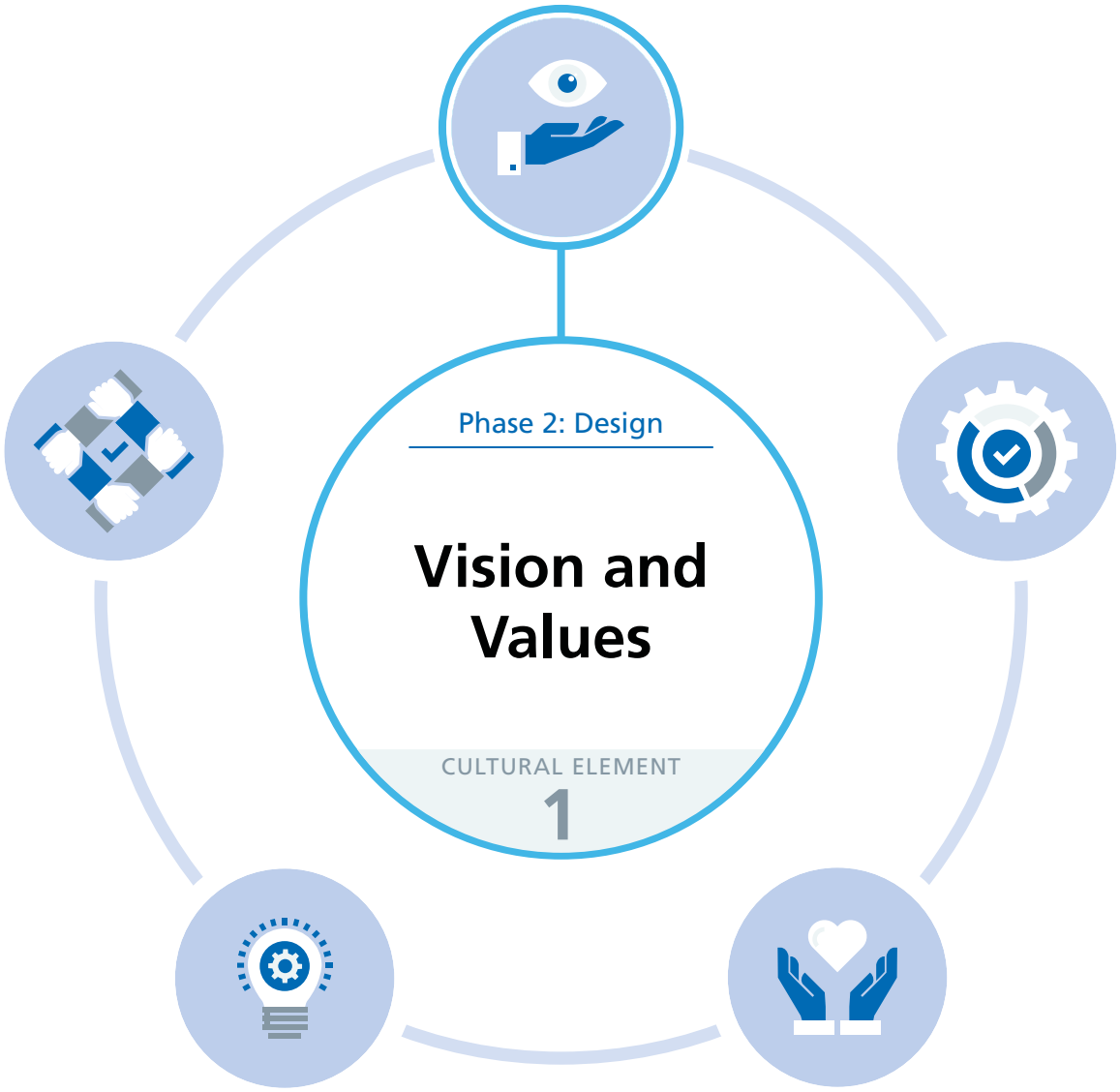
1. Vision and values
2. Goals and performance
3. Support and compassion
4. Learning and innovation
5. Teamwork

Each cultural element is introduced with an overview of that element.

This is followed by a series of documents summarising the evidence on interventions that will support the development of the cultural element and which you can include in your leadership strategy.

After each evidence summary, there is a link to take you to the fuller evidence base document, links to case studies, other useful resources and further reading.

Please note that as stated earlier, there are over 50 interventions and it will not be necessary to consider all of them for your strategy. Select the ones that best reflect the outputs from the diagnostic work you carried out during Phase 1.



- Values-based recruitment
- Values-based appraisal
- Values-based induction and transition
- Succession planning
- Values-focused curricula
- Annual talent review cycle

Introduction

SUMMARY

Organisational culture exerts a profound influence on the behaviour of anyone who works in, or interacts with, an organisation. It is 'the way we do things around here'. Culture powerfully shapes how people deliver care, manage their work, interact with patients, colleagues and carers, develop new and improved ways of delivering services; it also affects quality of team work and collaboration.

Attempts to change culture to ensure high performance – particularly when the environment is dynamic – are complex and challenging, and can have unpredictable outcomes. So it is important to understand and specify the core cultural characteristics for high performance in healthcare.

The single most malleable and powerful influence on the culture of modern organisations is leadership. This includes leadership from more strategic roles through to the front line, informal as well as formal. It reflects leadership processes as well as the qualities of the individuals who occupy leadership positions.

Within healthcare, compassionate and collective leadership is necessary if patients and service users are to receive continually improving, high quality, compassionate care. This is because, to ensure high quality care, all staff must be engaged and committed. Every interaction, by every member of staff, every day, influences the extent to which there are cultures of high quality and compassionate care.

To nurture a high performance culture, we need leaders, leadership behaviours and leadership collaboration aligned around reinforcing the vision, values and behaviours that are core to the desired culture. To achieve this, we must develop and implement compassionate and collective leadership strategies that ensure our organisations have the leaders they need. These leaders will display behaviours focused on the vision, reinforce the core values of high quality care cultures, and work compassionately and collectively to nurture the culture required for high performance.

This section includes:

- Values-based recruitment
- Values-based appraisal
- Values-based induction and transition
- Succession planning
- Values-focused curricula
- Annual talent review cycle.

Values-based recruitment

SUMMARY

Values-based recruitment is a method of recruiting staff whose values are a good fit with your organisation's values while making sure the recruitment process communicates the organisational values to potential recruits at an early stage.

What is it?

Values-based recruitment (VBR) is a method of attracting and selecting employees whose personal values and behaviours align with the organisation's values.

Values are principles or standards that influence behaviour – literally, they are what we value, or what we judge as important in life.

Organisational values are the shared values of those in the organisation – particularly leaders, as well as the workforce in general.

Why is it important?

An organisation's values are fundamental to determining how people behave – in particular, whether the focus is consistently on ensuring high quality patient care. Most reports into failings of NHS organisations, such as Mid Staffordshire NHS Foundation Trust, attribute them to culture and leadership – in other words, values.

What is the evidence?

Research has revealed the importance of ensuring a fit between the values of the organisation and of new staff – so-called 'person-organisation fit.' The better the fit, the more committed a new employee is to their organisation and the longer they stay. This is especially true during periods of organisational change.

Given the difficulties of attracting and retaining staff in the NHS, it is vital to use the recruitment process to emphasise the values that matter to staff generally and to the organisations that make up our healthcare system.

Read the full summary here with guidance and tips.

Values-based appraisal

SUMMARY

Values-based appraisals reinforce the core elements of culture in the organisation. They make sure everyone is clear about what is most important, and help people stay focused on the areas that will ensure organisational effectiveness for patients and staff.

What is it?

The values-based approach to appraisal is designed to ensure the appraisal process reinforces the organisation's values. It does this by making clear to everyone (regardless of seniority) that the main way their performance is evaluated is based on the extent to which they model the organisation's values.

In practice, it involves:

- agreeing objectives aligned with core organisational values
- helping the staff member ensure their job performance is aligned with core organisational aims
- making sure they feel their efforts to implement the values in their work are recognised, valued and appreciated.

Why is it important?

Standard appraisals are often ineffective. Effective appraisals are powerful and helpful conversations rather than tick-box processes. But most NHS staff indicate that their appraisal conversations do not involve agreeing objectives for their work and/or do not help them do their jobs better and/or do not leave them feeling valued and respected by their employing organisation (Dawson et al 2011).

Values are crucial to how we behave. Values define the culture of the organisation: 'the way we do things around here.'

What is the evidence?

Research has shown the importance of appraisals in predicting patient mortality in the NHS acute sector. Hospitals that ensured staff had helpful appraisal conversations had lower levels of mortality. But data also shows that the quality of the appraisal conversation makes a significant difference to outcomes in organisations across all domains (mental health, community and acute trusts).

Read the full summary here with guidance and tips.

Values-based induction and transition

SUMMARY

Building induction and transition processes around organisational values enables staff to perform more effectively and helps them understand the vision and values underpinning the organisation's culture, to ensure high quality care.

What is it?

Each employee is on a career journey that will change over time. Each change, whether to a new role, team or organisation or simply a new way of working, is known as a transition. Values-based induction and transition involve supporting new staff to successfully navigate their entry to the organisation, and helping existing staff adapt and integrate into new situations with minimal stress and maximum growth and development.

Why is it important?

Managing inductions and transitions is an important part of minimising unnecessary stressors that could contribute to anxiety, stress or burnout. Poorly managed workplace inductions and transitions have been described as 'trigger events' that knock staff off balance and interfere with their emotional wellbeing and their ability to perform effectively. They are also likely to distract staff from focusing on the vision and organisational strategy and compromise overall quality of patient care.

Taking the time to support inductions and transitions effectively is important not only for individual performance, but for the organisation's overall performance and for reinforcing the vision and values underpinning the organisation's culture.

What is the evidence?

Considerable evidence demonstrates the importance of well-managed inductions and transitions:

- Realistic job previews at induction reduce subsequent turnover dramatically
- Inductions that reinforce the sense of 'value fit' between new staff members and their organisations aid the induction and transition process. The more that staff experience compassionate cultures focused on high quality care in their induction process, the more likely they will be to have that sense of 'value fit', and therefore be likely to stay with the organisation rather than leave
- Good progress has been made on developing effective strategies for socialising new staff into organisations.

Read the full summary here with guidance and tips.

Succession planning

SUMMARY

Identifying future leaders can help ensure a sustainable workplace culture and consistent performance that continues beyond the current leadership's lifespan.

What is it?

Succession planning involves identifying, developing and supporting potential leaders and managers to move into senior, significant or hard-to-fill positions, either in the short or long term.

Why is it important?

Making sure organisational values and vision are maintained and strengthened over time is fundamental to sustaining a culture of high quality, continually improving and compassionate care. Leadership is vital to this.

Identifying potential successors as far as possible, and preparing them for future roles, ensures continuity and sustained performance. By ensuring consistency of leadership values over time, organisations can make sure they have leadership skills, knowledge and attitudes that they need to meet the challenges they face currently and in the future.

What is the evidence?

Research into succession planning suggests that the best organisations integrate leadership development and succession planning systems by:

- developing the organisation's mentor network
- giving potential leaders project-based learning experiences
- exposing potential candidates to a wide range of colleagues across the organisation
- maintaining a supportive organisational culture.

Healthcare organisations often lack effective succession planning strategies. Research suggests this leads to problematic consequences in terms of organisational performance.

Read the full summary here with guidance and tips.

Values-focused curricula and learning

SUMMARY

Curricula in healthcare learning need to be underpinned by the core values that our staff must have to ensure high quality patient care.

What is it?

People across healthcare undertake training – from medical students and nurses to allied health professionals, managers and administrators. The curriculum or programme that each person follows will influence the way they carry out their work and the quality of care they provide.

Values-focused curricula continually reinforce the NHS's core values, particularly those underpinning high quality care cultures. For this reason, we recommend that trusts advocate for curricula nationally and locally to be values-focused, and ensure that values are incorporated into their internal learning and development programmes.

Why is it important?

Values-focused learning reinforces the values underpinning high quality care from the start of people's training and careers. This equips today and tomorrow's NHS staff with the direction, alignment and commitment to the values essential for promoting the health of our communities. When we design training curricula for health and social care staff, we must make sure the core values of high quality care organisations run through them, from start to finish.

What is the evidence?

Three major programmes of study highlighted several qualities shown by leaders in the best-performing healthcare organisations:

- a study of cultures of quality and safety in the English National Health Service
- analysis of NHS national staff survey data from more than 350 organisations surveyed each year from 2004 to 2011, sampling the national workforce of 1.4 million employees
- extensive data on the performance of healthcare teams amassed over a 30-year period of research in the NHS, showing the links between quality of teamworking and quality of care.

Read the full summary here with guidance and tips.

Annual talent review cycle

SUMMARY

An annual review of staff performance and potential is a key part of succession planning in providing an informed approach to recruitment, talent management and leadership development.

What is it?

An annual talent cycle is a process in which managers and leaders review their staff's performance and potential. They then draw on this information to design leadership development, plan for succession and ensure their staff are supported to develop the knowledge, skills, attitudes and values they need to help achieve the organisation's vision.

A talent management system is an organisation's overall system for attracting, developing and retaining employees with the capabilities and commitment needed for current and future organisational success.

Why is it important?

All NHS organisations need to conduct an annual talent review because it will enable them to take informed and intelligent approaches to recruitment, talent management and leadership development.

A minority of NHS organisations believe they do not have the time or resources to engage in talent management, recruitment strategies and leadership development. The reality is that without a mature and informed approach to these issues, NHS organisations will not have the capacity and long-term resilience to respond to the challenges we face in delivering health and social care in the future. Recruitment, talent management and leadership development strategies are necessities, not luxuries.

What is the evidence?

There is some case study evidence that organisations that take a strategic approach to talent management by conducting regular reviews are more successful in performing well than those that do not (APQC 2004). More research is needed to identify what approaches to talent reviews are most successful (Lewis and Hackman 2006, Collings and Mellahi 2009).

Read the full summary here with guidance and tips.

NHS Improvement

- Leader role job design
- Inclusive recruitment
- Regular leadership forecast update
- Goal setting and goal review
- Setting and using team goals
- Providing feedback on behaviour and performance
- 360 degree feedback
- Measuring compassion

Introduction

SUMMARY

NHS staff are often overwhelmed by tasks and unclear what their priorities should be. This can result in stress, inefficiency and poor quality care.

Vision and mission statements about high quality and compassionate care provide an inspiring direction for staff in NHS organisations. But if we want to create cultures that are truly focused on high quality care, we need to translate these statements into clear, aligned and challenging objectives, or goals, at all levels of the organisation.

This will radically transform healthcare organisations' effectiveness and efficiency.

Goal setting is a core part of performance management and is an area of theory that is particularly well supported in the research literature (Locke and Latham 2013). In particular:

- Goal setting results in markedly higher performance than no goal setting (Locke and Latham 2013)
- Specific goals are more effective than 'do your best' goals. Goal setting results in higher performance if goals are challenging, specific and measurable.

Creating a culture focused on high quality care requires clear, aligned and challenging objectives at each level in the organisation, to make sure this care is the priority.

Leader role job design

SUMMARY

Leader roles need to be designed strategically and include key elements such as feedback and autonomy, to help leaders perform at their best and bring out the best in those who they lead.

What is it?

Leadership in health and social care organisations must provide:

- direction – achieving agreement on what the collective is trying to achieve together
- alignment – effectively co-ordinating and integrating aspects of the work so it fits together and serves the shared direction
- commitment – people and teams making the collective's success – not just their individual success – a personal priority (Drath et al 2008).

For leaders to do this, their roles have to be designed effectively.

Why is this important?

Key values for high quality care

If the organisation's collective leadership ensures direction, alignment and commitment, leadership roles must combine elements of good job design:

- Skill variety – the extent to which people are required to draw on diverse job skills and abilities. Meaningful work requires that people use their capabilities.
- Task identity – the extent to which a job allows people to complete a whole, identifiable piece of work, the outcome of which they can perceive.
- Task significance – the extent to which the output of work has an impact on others, either people at work, or outside such as service/product users.
- Autonomy – freedom to decide how to work and to accomplish goals. Autonomy at work is central to developing a sense of personal responsibility.
- Feedback – performance feedback is critical for enabling people to gain knowledge of the results of their work.

What is the evidence?

For managers and practitioners, the research results point to the value of considering carefully, and investing in leader role job design. The returns in terms of performance, wellbeing and – importantly – motivation appear well established in the research literature.

Read the full summary here with guidance and tips.

Inclusive recruitment

SUMMARY

With many people experiencing discrimination in the workplace – including the NHS – it is important to take a proactive approach to help redress the balance when it comes to recruitment, promotion and performance management.

What is it?

Inclusive recruitment is a working practice designed to right the wrongs that people from various minority groups experience, including discrimination in relation to selection, promotion and performance management.

Why is it important?

People from various minority groups have been subjected to discrimination over many decades within the NHS. Recent research shows little progress has been made in the past 20 years to address discrimination against black and minority ethnic (BME) staff in the NHS.

We know that discrimination profoundly and pervasively damages the health, wellbeing and quality of work life of the many staff affected (Tomlinson and Schwabenland 2010). Research also shows that in NHS organisations where staff are disengaged, demoralised or demotivated (for whatever reason), they will generally provide poorer patient care (Dawson et al 2011).

What is the evidence?

There is strong evidence from within the NHS that where staff in patient-facing roles are representative of the communities they serve, trusts perform significantly better in terms of care quality and financial performance (King et al 2011). This is at least partly due to the greater compassion and higher levels of civility that patients experience in these trusts (King et al 2011).

But the issue is not simply a business case for change: it is a profound moral, social and cultural issue that we must all address collectively, from a values and virtue perspective (van Dijk et al 2012).

Read the full summary here with guidance and tips.

Regular leadership forecast update

SUMMARY

An annual update of your leadership forecast ensures that your organisation's changing needs inform your leadership strategy and talent management programmes.

What is it?

This method involves annually updating the leadership workforce analysis (phase 1 toolkit). The leadership workforce analysis helps you collect information necessary to evolve the leadership strategy and resulting talent management priorities.

This tool:

- focuses on the likely future state of 'key roles' and hard-to-fill roles
- covers high-level likely future states of your workforce as a whole
- gathers information on the future organisational design.

Why is it important?

In a rapidly changing environment, it is important to forecast your leadership workforce needs, and to regularly revise them.

Because those in key roles have a major influence on the organisation's culture, this tool helps you undertake a talent review and gap analysis to support compassionate and collective leadership. It does this by ensuring you have leaders in post substantively, rather than vacancies or interim position holders, and enough individuals in the leadership pipeline –with the skills, motivation and appropriate values and behaviours – to be ready when there are vacancies or to step into new leadership roles.

What is the evidence?

Leadership forecast updates play a central role in ensuring that the overall leadership strategy is relevant, adaptable, and specifies the collective capabilities of formal leaders and all staff members needed for compassionate and collective leadership.

The approach draws on the extensive work of the Center for Creative Leadership (McGuire and Rhodes 2009, Hughes et al 2013) in working with organisations in healthcare and other industries to develop and implement leadership strategies.

Read the full summary here with guidance and tips.

Goal setting and goal reviews

SUMMARY

Goals help people stay motivated, perform well and be innovative. But for effective performance management, goals must be challenging, specific and agreed.

What is it?

When teams and individuals have clear objectives or goals at work, they are motivated to work harder and to develop new and improved ways of working. This has been a well-established fact for 60 years.

Everyone working in an organisation needs clear objectives, ultimately derived from the organisation's vision, mission and strategy. The board should have its own five or six clear team objectives. (Many do not.) So should each directorate and department, every team in the organisation and, ideally, every individual.

Why is this important?

A key cultural component for high quality care cultures is clear goals or objectives at every level. Staff in the English NHS report often feeling overwhelmed by tasks and unclear about their priorities, resulting in stress, inefficiency and poor quality care (Dixon-Woods et al 2013). Creating cultures focused on high quality care requires clear, aligned and challenging objectives at every level of the organisation that prioritise this standard of care (West 2013). This is not the same as the target-driven culture of some governments and organisations to drive change in the system – without great success, the evidence suggests (Ham 2014).

Setting these clear objectives begins with the senior management team having a clear purpose and five or six clear objectives (Wageman et al 2008). This clarity of objectives must then be replicated at every level so that each directorate, department, team and individual (via their appraisal process) has clear objectives aligned with the organisation's purposes, vision, mission and values.

What is the evidence?

Goal setting is a core part of performance management and is one area of theory that is particularly well supported by research evidence. In particular, we know that:

- goal setting results in markedly higher performance than no goal setting
- goal setting results in higher performance, if goals are specific and measurable
- goals need to be challenging and agreed.

Read the full summary here with guidance and tips.

Setting and using team goals

SUMMARY

Setting clear goals for the team as a whole is essential if team members are to work collectively and effectively towards a common aim.

What is it?

Teams are created to perform a task that individuals working alone or in parallel could not complete, or could only complete with great difficulty. So the task defines the team, rather than the reverse. Once the task is identified, the team can then define its goals. These are the key priorities for the team's work, which all team members commit to work towards collectively.

We need to create teams when a task can best be undertaken by teams rather than simply because people are working in the same location. So, the starting point is defining the task (see the opposite).

Characteristics of appropriate team tasks

- They are complete tasks rather than a narrow component.
- The task creates varied demands that require interdependent working by people with differing skills.
- The task requires innovation and quality improvement.
- Team members are enabled to grow and develop through working on the task.
- Team members have a high degree of autonomy, with the freedom to decide how best to carry out the task (within sensible limits).

Why is this important?

Clarity of team goals is the single most important predictor of success in healthcare teams (Lyubovnikova and West 2013, West and Markiewicz 2016). However, many teams still do not have clear goals. In some cases, team members may disagree about what those goals are. In others, the goals may be stated in such an imprecise way that they are little more than feel-good statements, with no practical value being added to the team's challenge to reach its goal.

What is the evidence?

The most consistent predictor of team performance across many studies is the clarity of healthcare teams' goals (West and Anderson 1996, Goñi 1999, Poulton and West 1999, Borrill et al 2000, Cashman et al 2004, Dixon-Woods et al 2013). Yet few healthcare teams in our experience take the time to set clear goals.

Read the full summary here with guidance and tips.

Providing feedback on behaviour and performance

SUMMARY

Feedback plays a crucial role in shaping staff performance, but if it is not done effectively it can cause more harm than good.

What is it?

Effective performance feedback is helpful, accurate and timely information that enables individuals or teams to assess their progress towards their objectives and adjust performance accordingly.

Why is this important?

It is fundamental to performance management to give people and teams feedback about their performance because it enables people and teams to adjust their performance to ensure progress towards their desired objectives.

Effective feedback helps employees and teams by:

- highlighting what they are doing right, helping to build confidence
- clarifying progress towards objectives
- identifying areas for improvement
- helping to build competence, so they can do their jobs more effectively
- promoting engagement and involvement with the organisation, developing their sense of being valued by it.

What's the evidence?

The research produces some useful insights into which form of feedback (constructive or developmental) is most effective at changing behaviour.

Feedback to employees needs to be a balance of constructive ('positive') and developmental ('negative') information. Most feedback should focus on the constructive because this helps people feel positive, confident and motivated. However, developmental feedback (which reveals gaps between desired and actual performance) is important to performance management too. Without it, employees have no information about how to improve (Ilgen and Davis 2000).

Read the full summary here with guidance and tips.

360 degree feedback

SUMMARY

360 degree feedback, also known as multi-rater feedback, refers to the 360 degrees in a circle. This is because it involves individuals seeking feedback from a wide range of colleagues, at all levels, with whom they come into contact in their working lives.

What is it?

The approach is designed to help leaders identify their leadership strengths and development needs. The leader shares a standardised questionnaire with multiple colleagues to invite ratings of their behaviour and performance. The results are then gathered to provide aggregated or individual ratings.

The aim is to prompt anonymous and confidential feedback from multiple sources. Together, these provide a leader with collective insight and self-awareness about how others perceive them in their role.

This feedback comes from subordinates, peers, supervisors and 'others' – people who hold valuable perspectives but may not fit into these categories.

Why is this important?

In general, leaders do not accurately gauge how effectively they perform their leadership roles. Many dramatically over or under-rate themselves when compared to ratings from colleagues (Alimo-Metcalfe 1998). Leaders whose self-perceptions match their staff's perceptions are rated as demonstrating higher levels of leadership effectiveness (Bass and Avolio 1994). This suggests that leader self-awareness is crucial for effectiveness.

What is the evidence?

When it comes to the effectiveness of 360 feedback, studies have produced mixed results (Seifert et al 2003). Some suggest positive effects, while others suggest no effects at all. In a review of 131 studies (not confined to leadership), Kluger and DeNisi (1996) found only a weak positive effect of 360 feedback on performance. Indeed, in one-third of studies the relationship was negative.

However, the Center for Creative Leadership highlights important leadership lessons from its research that support using 360 feedback for development in the NHS.

Read the full summary here with guidance and tips.

Measuring compassion

SUMMARY

As a core value of the NHS, it is vital that we measure performance in terms of compassion to chart progress and compare results with other organisations.

What is it?

Compassion can be understood as having four components:

- attending
- understanding
- empathising
- helping.

Measuring compassion involves assessing the extent to which an individual displays compassion in their work.

Why is it important?

The NHS was founded in 1948 on the basis of the core value of compassion. The post-war generation made a commitment to providing care for all those who needed it, regardless of status, wealth, ethnicity, age or gender. The very founding of the NHS was an expression of compassion as a core national value. Today, most NHS staff have at some point decided to dedicate a major part of their lives to caring for others. So compassion is the core work value of virtually all NHS staff.

Research evidence

There are several methods of assessing compassion but perhaps the simplest is using psychometric measures. However, the academic literature suggests there are no well-established measures of compassion available as yet, though some promising approaches are available.

There is also evidence of factors that act as barriers or inhibitors of compassion.

Read the full summary here with guidance and tips.

- Compassion-based recruitment
- Developing compassionate leadership
- Developing emotional intelligence
- Inclusion: listening to all voices
- Coaching
- Mentoring
- Inclusive leadership development
- Diversity and equal opportunities training
- Compassionate behaviour training
- Identity-based talent management

Introduction

SUMMARY

The NHS was founded in 1948 on the basis of the core value of compassion. The country made a commitment to providing care for all those who needed it, regardless of status, wealth, ethnicity, age or gender. Virtually all NHS staff, at some point, have made a decision to dedicate a major part of their lives to caring for others in their communities. Compassion is the core work value of virtually all NHS staff. In organisations where the core value is compassion, staff motivation, wellbeing and effort are sustained and nurtured.

Compassionate behaviour is manifested in interactions with patients/service users, carers, colleagues, fellow team members, other professional groups and those we lead, along with anyone else we have contact with during the course of our work. The sum total of our interactions shapes the organisation's culture. That, in turn, has a direct effect on quality of patient care (West and Chowla 2017).

Compassionate cultures are nurtured when leaders and all staff behave with compassion (Kanov et al 2004). Compassion spirals out, so that those who receive compassion are themselves more likely to direct caring and supportive behaviours towards others (Lilius et al 2011). This replenishes the emotional resources that caregivers need – especially in a caring environment – and cushions against stress and burnout (Lilius et al 2011, Dutton et al 2014).

Where health service staff report that they are well led and supported by their supervisors, patients say they too are treated with respect, care and compassion (West et al 2011). The average level of staff engagement in NHS organisations predicts care quality and financial performance, staff health and wellbeing, patient satisfaction and lower patient mortality, staff absenteeism and stress (West et al 2011).

Overall, when healthcare staff feel their work climate is positive and supportive (as evidenced by compassionate, coherent, integrated and supportive leadership and people management practices), quality of care, patient experience and organisations' financial performance are significantly better.

References

Dutton JE, Workman KM, Hardin AE (2014) Compassion at work. *Annual Reviews of Organizational Psychology and Organizational Behaviour* 1(1): 277–304

Kanov JM, Maitlis S, Worline MC, Dutton JE, Frost PJ, Lilius JM (2004) Compassion in organizational life. *American Behavioral Scientist* 47 (6): 808–827

Lilius JM, Kanov J, Dutton JE, Worline MC, Maitlis S (2011) Compassion revealed: What we know about compassion at work (and where we need to know more). In Cameron K, Spreitzer G (eds) The Oxford handbook of positive organizational scholarship. Oxford University Press, New York

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In Gilbert P (ed) Compassion: concepts, research and applications: 237–257. Routledge, London

West MA, Dawson JF, Admasachew L, Topakas A (2011) NHS staff management and health service quality: Results from the NHS Staff Survey and related data. Report to the Department of Health. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 21 July 2017)

Compassion-based recruitment

SUMMARY

Prioritising compassion right from the start of the selection progress helps identify staff whose values are aligned with organisational values.

What is it?

Recruiting and selecting for compassion is an approach to finding employees whose personal values and behaviour align with the organisation's core value of compassion. The process highlights candidates whose values and behaviour indicate a strong orientation of compassion towards others. Having this as a named process also communicates the organisation's commitment to the core value of compassion at an early stage in the potential employee's involvement with the organisation.

Why is this important?

Recruitment and selection decisions reinforce to staff at all levels what is important to the organisation and to the NHS. This is especially important where decisions about selection are based on fine-grained academic performance, and compassion is not considered.

Organisations that have a core value of compassion sustain and nurture staff motivation, wellbeing and effort. Compassionate care is also what patients want. So actively maintaining a compassionate orientation across an organisation helps produce a strong culture that affects the outcomes that matter.

What is the evidence?

When staff feel valued and cared for (in other words, perceived organisational support), they tend to feel more satisfied with their jobs and more committed to their organisations. There is considerable evidence that this is true in the NHS. Organisational support is associated with high levels of patient satisfaction, care quality and even financial performance in healthcare organisations.

Read the full summary here with guidance and tips.

Developing compassionate leadership

SUMMARY

To ensure that compassion plays a core role in organisational culture, leaders need to model the behaviours and values they want to see in their staff.

What is it?

Developing compassionate leadership involves developing the knowledge, skills, attitudes and values of leaders at every level, so they model compassion in how they lead. Compassionate leaders learn to:

- attend to the people they lead
- understand the challenges they face
- empathise with them
- take action to serve or help them

Why is this important?

The four domains of compassionate leadership are particularly powerful in healthcare, where the workforce is largely composed of highly skilled and motivated professionals who are intent on doing their jobs to the highest possible standard.

When leaders demonstrate compassion, they provide support consistent with the core values of the people they lead. This legitimises compassion as an endeavour worthy of valuable time and organisational resources. In turn it encourages and empowers those they lead to respond compassionately in the face of suffering.

What is the evidence?

In the best-performing healthcare organisations, compassionate leaders (from the top to the front line) make it clear that high quality, compassionate care is the core organisational purpose and priority. It also requires compassionate performance management, by negotiating and agreeing clear, aligned and challenging objectives for teams at all levels, focused on providing this care. This is quite different from using target-driven cultures to drive change – an approach that has limited success.

Read the full summary here with guidance and tips.

Developing emotional intelligence

SUMMARY

Cognitive skills such as memory and problem solving play an important role in any workplace, but today's healthcare sector needs emotional intelligence too, to ensure high quality interactions not only with colleagues but also with patients/service users.

What is it?

Developing emotional intelligence is about helping leaders to improve their emotional quotient (EQ) by:

- knowing their emotions
- managing their emotions
- motivating themselves
- recognising and understanding other people's emotions
- managing relationships.

Compassion is at the heart of all these behaviours. Developing emotional intelligence is not about learning how to manipulate or manage impressions and feign interpersonal connections. This type of 'surface acting' erodes the trust of staff working with such leaders. Instead, it is about understanding ourselves and others and managing relationships in a caring, sensitive, intelligent and supportive way.

Why is it important?

As in all other organisations, staff in the NHS look to leaders to gauge emotional cues as they are more visible and engage in more interactions with different types of staff. If leaders set a tone of positivity, empathy, reflection and honesty, staff are more likely to have greater resilience, efficacy, hope and optimism. This, in turn, will improve the quality of interactions they have with other staff and, importantly, the patients they serve.

So developing the capacity to self-regulate emotion is a critical competency for leaders in the NHS. Those with stronger emotional intelligence are skilled in their mastery of different leadership styles. Through a deeper understanding of self and greater attentiveness to others, emotionally intelligent leaders can switch between leadership styles, depending on the situation.

What is the evidence?

Historically, intelligence was only thought of as intelligence quotient (IQ): the level of cognitive ability, including memory and problem solving. Over the years, there has been a move away from this definition of intelligence towards non-cognitive factors that may influence performance in the workplace, such as emotional intelligence (EI).

Research by psychologist Daniel Goleman and colleagues shows that when leaders foster positive climates, they are better able to draw out the best in others –particularly those who work directly with them.

Read the full summary here with guidance and tips

Inclusion: listening to all voices

SUMMARY

For healthcare organisations to meet the needs of their staff, and of everyone in the communities they serve, they must develop the skills and structures to listen to the voices of everyone affected by their work.

What is it?

Inclusion and listening to all voices in healthcare involve ensuring that the views and ideas of all staff, patients and the wider community are heard and integrated into the process of developing healthcare. Healthcare can then best meet the community's needs.

In a climate of inclusion, everyone is listened to respectfully, positively and with authenticity. This helps provide healthcare of the highest quality that matches the aspirations and expectations of staff, patients and the wider community.

Why is this important?

When staff are consulted, listened to and involved in shaping change, they are more likely to bring wisdom, compassion, intelligence, commitment, courage and emotional intelligence to their work.

Staff are more committed and satisfied when their leaders listen and respond to them. Staff will also be more engaged, and we know that engagement is the strongest staff survey predictor of healthcare organisations' performance: services are likely to be better and resources used more efficiently. Discussions with staff about frontline challenges and problems will generally lead to better solutions (because of their expertise) than when their voices are not heard.

What is the evidence?

Taking the time to listen to all stakeholders (including staff, patients, carers, patient groups, community representatives and other organisations) results in higher levels of successful innovation that improves services and performance.

Read the full summary here with guidance and tips.

Coaching

SUMMARY

A collaborative approach to learning and development empowers people to set their own goals and explore their own solutions to problems.

What is it?

Coaching is a collaborative relationship between a coach and the person receiving coaching, designed to support the person to attain their professional or personal goals. Organisations use it to enhance and manage performance. It is suitable for managers and non-managers.

Coaching is intended to help people reflect on, explore and clarify problems, set objectives and review performance. It can also help them learn new skills, handle difficult problems, manage conflicts or learn to work effectively across boundaries.

Why is this important?

- Coaching can provide many benefits, particularly support and feedback for individuals during times of change, professional development and challenge and for those with strategic responsibilities
- Coaching is seen as a valuable intervention for leaders in the NHS who are required to demonstrate learning agility and flexibility in a dynamic environment
- Coaching is a helpful skill that NHS leaders can use themselves to develop and empower the people who report to them or colleagues
- Coaching can help managers make sense of challenging situations and conflicts and deal with them effectively.

What is the evidence?

There has been limited research examining the effectiveness of coaching, but it has been favourable. More solid evidence is needed to demonstrate effectiveness in predicting team and organisational performance outcomes. Much depends on the quality of coach training, clarity of structure and processes of coaching, the underlying theoretical model, supervision of coaches and clarity about the overall purpose.

Read the full summary here with guidance and tips.

Mentoring

SUMMARY

A mentoring partnership can help staff clarify their aspirations and goals and develop skills while benefiting from a supportive, reassuring relationship.

What is it?

Mentoring involves a committed long-term relationship between an experienced (usually senior) leader in an organisation and a more junior or less experienced individual. The mentor provides:

- career support such as sponsorship, job assignments, coaching and high visibility for the individual to help them move in the direction of their career aspirations
- social support including advice, encouragement and compassion to ensure the individual receives emotional support as well as practical guidance and advice
- a role model acting as an example of wise and compassionate leadership. It is closely related to coaching.

Why is this important?

Mentors help leaders and potential leaders by offering acceptance, encouragement, counselling, sponsorship, protection, challenging assignments, exposure and visibility. This results in learning and support for individuals, with far more effective leadership development than would otherwise be the case. Mentoring can facilitate adjustment, learning and stress reduction during difficult job transitions. It can also contribute to greater organisational commitment and lower turnover among leaders and potential leaders.

Mentoring also benefits mentors themselves.

What is the evidence?

The research evidence is clear in suggesting that mentoring is associated with better performance, more recognition, increased pay, better career opportunities and more promotions. Mentoring appears to result in more career advancement and success for the protégé and higher levels of organisational commitment.

Read the full summary here with guidance and tips.

Inclusive leadership development

SUMMARY

Prioritising under-represented or minority groups in leadership development plans is important for redressing the inequalities across healthcare and society.

What is it?

If an organisation wants a culture of inclusion, appreciation and care, it is important that it runs a talent development programme focused on minorities. This ensures participants and organisations can realise the full value of development initiatives and ensure that all groups are properly included.

Why is this important?

The NHS's culture needs to be sustained by the core values in the NHS Constitution, including respect and dignity, compassion and inclusion. Leadership development has to be inclusive so as not to deny opportunity to staff simply because of their demographic characteristics.

However, despite many calls to address the diversity gaps across the NHS workforce, progress is slow (Kline 2014).

What is the evidence?

An employee's demographic characteristics will have a major impact on their opportunities for challenge, leadership development and career progression. Staff who are female, or from BME or lower socio-economic groups are likely to be told they need more development, while receiving fewer opportunities for it.

Better workforce representation leads to clear benefits for the organisation and its service users/patients. It is essential that leaders of organisations in the NHS quickly reflect the demography of the patient population they serve to minimise health inequalities. This is vital not only for moral reasons, but because there is evidence that diversity benefits organisational outcomes in the NHS.

Read the full summary here with guidance and tips.

Diversity and equal opportunities training

SUMMARY

Redressing inequality in healthcare and society means actively helping people to reconsider attitudes and become more aware of their own biases.

What is it?

Diversity training is a set of instructional programmes or educational activities to facilitate positive interactions between groups, reducing prejudice and discrimination, and enhancing participants' skills, knowledge, and motivation to interact with a diverse range of other people.

Why is this important?

There is a clear and compelling need to cultivate a more diverse and effective NHS leadership. Discrimination, unconscious bias and stereotyping continue to be widespread – in society and in the NHS.

Staff who experience an organisational culture where implicit attitudes and stereotypes go unchallenged or worse, are encouraged, may be more likely to deliver suboptimal care and put patients' lives at risk.

What is the evidence?

Diversity training is important because the evidence tells us that bias has profound effects. We also know that conventional diversity training can boost individual knowledge and somewhat reduce reported discrimination in organisations. Beyond that, it has a limited effect on changing cultures, although some strategies appear more successful than others in bringing about wider positive change.

So although individuals' attitudes and biases can compromise patient care and an organisation's vision for an inclusive culture, they can be trained and controlled. If employees have a self-determined, internal motivation to manage their prejudices, this helps reduce discriminative behaviours and unequal opportunity. This is an important guiding principle for any initiative seeking to reduce implicit biases in the organisation.

Read the full summary here with guidance and tips.

Compassionate behaviour training

SUMMARY

Compassion is essential in high quality healthcare. It comprises skills and behaviours that can be developed to ensure proactive and empathetic responses to patients, families and colleagues.

What is it?

Compassionate behaviour training develops the core skills of compassion. In an organisational context, compassion can be understood as having four components (Atkins and Parker 2012, Worline and Dutton 2017):

- attending – paying attention to the other and noticing their suffering
- understanding – what is causing the other's distress, by making an appraisal of the cause
- empathising – having an empathic response: a felt relation with the other's distress
- helping – taking intelligent (thoughtful and appropriate) action to serve the other or help relieve the other's suffering

Why is this important?

Compassion is the core work value of virtually all NHS staff. Staff motivation, wellbeing and effort are sustained and nurtured in organisations where the core value is compassion. Compassionate care is also what patients want. It is therefore important to develop compassion among team members, among the team as a whole and as a feature of the organisation's culture.

Contrary to widespread belief, compassion (and self-compassion) can clearly be learned and developed. Simple training and supportive organisational contexts can release the power of compassion in the workplace.

What is the evidence?

Much evidence suggests the four behaviours of compassion can be developed in organisations and shows the profound effects of creating compassionate cultures.

Leaders and all staff can nurture compassionate cultures by behaving with compassion. Compassion can spiral out, so that those receiving it are better able, or more likely, to be caring and supportive towards others. This may well replenish the emotional resources that care-givers need, especially in a caring environment, and cushion against stress and burnout.

Read the full summary here with guidance and tips.

Identity-based talent management

SUMMARY

Having a strong 'identity fit' – a feeling that one 'belongs' in an organisation – plays a strong part in employees' engagement and motivation. Proactively managing diversity can help improve retention and quality of care.

What is it?

Identity-based talent management focuses on encouraging all to achieve their potential and find a strong sense of 'identity fit' in their NHS organisations. This is especially relevant for members of groups traditionally subject to widespread and consistent discrimination.

The theory of social identity argues that our work and non-work lives interact to powerfully influence the extent to which we experience a sense of identity fit at work. This sense is increased when an employee can positively identify with their colleagues and the organisation's leaders. Where the identity fit is high, employees are more committed, engaged and motivated. Where it is low, turnover and engagement are significantly lower.

Why is this important?

Workforce diversity improves patient care, minimises health inequalities and nurtures inclusive cultures. NHS organisations can improve the diversity of their workforce by tailoring their talent management practices to be more encouraging and accommodating of difference, increasing engagement, promotion and retention of minority group individuals.

What is the evidence?

Poor employee identity fit can lead to higher levels of turnover, reduced job satisfaction and increased perceptions of injustice. A recent study of 60,602 NHS staff found a strong negative relationship between ethnic representation among leadership and perception of mistreatment at work. On the other hand, stronger identity fit can buffer against discrimination, bullying and abuse.

Read the full summary here with guidance and tips.

NHS Improvement

- Developing cultures of innovation
- Leading for innovation
- Recruiting for commitment to innovation and quality improvement
- Development for managing innovation
- Leading for quality improvement
- Secondments
- Developmental assignments
- Action learning
- Action learning sets

Introduction

SUMMARY

Organisations and systems doing NHS-funded work face a common set of performance and people development changes, with many under unprecedented pressure to improve performance in their services and existing operations, in a context of rising demand and constrained funding. It is widely accepted that "the English NHS cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy" (Ham et al 2016).

We know that innovation can enable modern healthcare organisations and systems to meet the radically changing needs and expectations of the communities they serve. Adequate financial support is a necessary precondition, but it is clear that more money on its own, without transformative change, will not be enough (West et al 2017).

After the Mid Staffordshire inquiry, the principal recommendations in the Berwick report, A promise to learn, a commitment to act (Berwick 2013), focused on supporting NHS staff to lead improvements in care by providing education and training in learning, quality and patient safety practices and innovation.

It also requires a supportive leadership and cultural context (West et al 2014, Dixon-Woods et al 2012). Senge (1990) describes leaders as 'designers, stewards, and teachers' who have a duty to their organisation to support the continual development of their own capacity to deal with complexity, and that of the workforce. This can be achieved through a clear vision that focuses on learning and innovation. So leadership that sparks inspiration and new ideas is important, but the real value lies in implementing these ideas in practice, to improve patient care (Øvretveit 2009).

By making sure that NHS organisational and systems environments are conducive to learning and innovation generally, and to quality improvement specifically, attempts to meet the challenges of modern healthcare are more likely to succeed. Leadership is central to this. Compassionate leadership, in particular, is a fundamental enabling factor that will create a culture of improvement and radical innovation across healthcare (West et al 2017).

References

Berwick D (2013) A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health, London

Dixon-Woods M, McNicol S, Martin G (2012) Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. *BMJ Quality and Safety.* Published online. Available at: http://qualitysafety.bmj.com/content/early/2012/04/27/bmjqs-2011-000760 (accessed 1 August 2017)

Ham C, Berwick D, Dixon J (2016) Improving quality in the English NHS: a strategy for action. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

Øvretveit J (2009). Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers. The Health Foundation, London

Senge P (1990) The fifth discipline: the art and science of the learning organization. Currency Doubleday, New York

West MA, Eckert G., Collins B, Chowla R (2017) Caring to change: how compassionate leadership can stimulate innovation. The King's Fund, London Available at: https://issuu.com/pinnaclegd/docs/web_caring_for_change

West MA, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1: 240–260

Developing cultures of innovation

SUMMARY

Cultures of innovation do not simply emerge within organisations: they need to be carefully nurtured through compassionate leadership that inspires vision, encourages collaboration and balances support with autonomy.

What is it?

Organisations can be described in terms of their cultures: meanings, values, attitudes, and beliefs or 'the way we do things around here' (Schneider et al 2017). Innovative cultures have these features (West and Richter 2007):

- a firm and shared belief among most staff in an appealing vision of what the organisation is trying to achieve
- a high level of interaction, discussion, constructive debate and influence among staff as they go about their work
- interpersonal and intergroup relationships characterised by trust, co-operative orientations and a sense of interpersonal support and safety
- organisational members who are consistently positive and open to members' ideas for new and improved ways of working, providing both encouragement and the resources for innovation – particularly those at the upper echelons (and there are few echelons)
- the ability to work to demands that are manageably high, with members under pressure but seeing this as a positive and manageable challenge rather than an impossible burden.

Why is it important?

Only innovation can enable modern healthcare organisations and systems to meet the radically changing needs and expectations of the communities they serve. Adequate financial support is a necessary precondition, but it is clear that more money on its own, without transformative change, will not be enough.

What is the evidence?

Cultures of innovation have six key elements that organisations and systems need to ensure compassionate leadership:

- inspiring vision and strategy
- compassionate and collective leadership
- positive inclusion and participation
- enthusiastic team and cross-boundary working
- skills, capabilities, systems and processes for innovation
- support and autonomy.

Read the full summary here with guidance and tips

Leading for innovation

SUMMARY

Innovation plays a vital role in modern healthcare, but instilling a culture open to innovation is complex. To succeed, leaders must understand how to create the right conditions for innovation, quality improvement and radical change.

What is it?

Leaders must understand how to lead for innovation if health and care organisations are to continually develop new and improved ways of delivering services. Leading for innovation focuses on the key knowledge, skills abilities and behaviours leaders that ensure high levels of innovation in teams and organisations.

Why is it important?

For the NHS to meet the challenges it faces, we must create conditions that encourage teams from top to bottom and end to end to develop and implement new and improved ways of doing things

So all leaders, from those in national bodies to front line supervisors, must understand how to lead for innovation. Quality improvement programmes are vital too. But if they are not to flounder, they must be implemented in the context of leadership that facilitates new and improved ways of doing things.

What is the evidence?

Research on high quality care cultures, cultures of innovation in healthcare and compassionate leadership reveal powerful links between the three. This argues for the potency of developing compassionate leadership for high quality and innovative cultures in healthcare.

Compassionate leadership creates the necessary conditions for innovation among individuals, in teams, in the process of inter-team working, at the level of organisational functioning as a whole and in cross-boundary or systems working.

Read the full summary here with guidance and tips

Recruiting for commitment to innovation and quality improvement

SUMMARY

If the NHS is to achieve the levels of innovation and quality improvement it needs, organisations must recruit for the skills and commitment to put these priorities first.

What is it?

Recruiting for commitment to innovation and quality improvement (QI) involves using recruitment and selection processes that seek and appoint staff who:

- value the opportunity to innovate and improve quality in the course of their work
- see their jobs as requiring innovation and QI
- are committed to working with fellow team members to develop and implement ideas for new and improved ways of doing things.

Why is it important?

Teams and individuals in the NHS must seek and develop ideas for new and improved ways of providing care and delivering services if the NHS is to meet the challenges it faces. That will require a workforce and leaders committed to innovation and QI as a way of working, not simply an occasional add-on. Recruitment for commitment to innovation and QI is therefore vital. This is recognised too in the national framework for improvement and innovation – *Developing People – Improving Care* – endorsed by all the NHS national bodies.

What is the evidence?

Caring to change reviews research on innovation and shows that compassionate leadership – a core principle of *Developing People – Improving Care* – is particularly powerful in filtering the conditions for innovation (West et al 2017).

Compassion also creates psychological safety: staff feel confident in speaking out about errors, problems and uncertainties. They feel empowered and supported to develop and implement ideas for new and improved ways of delivering services. They also work more co-operatively and collaboratively in compassionate cultures, in climates characterised by cohesion, optimism and efficacy.

Compassionate leadership is an enabling condition for innovation across sectors (Amabile and Khaire 2008, Worline and Dutton 2017) and a prerequisite for sustained innovation in health and care services.

Read the full summary here with guidance and tips.

Development for managing innovation

SUMMARY

Managing innovation involves more than overseeing change: it means understanding why people resist change and making sure individuals and teams work in a culture of inspiration and trust, so they can perform at their best and implement their ideas for innovation and quality improvement.

What is it?

Development for managing innovation and change involves understanding the innovation process, team innovation and change management, and putting that understanding into practice.

Why is it important?

The NHS faces huge challenges of improving patient care at a time of staff shortages and unprecedented financial challenges. "The NHS in England cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy" (Ham et al 2016).

So all leaders and potential leaders need to understand how to manage innovation and change. Because innovation and change are so important in healthcare, understanding innovation and change processes equips people to manage them better, whether they are the leaders or the implementers of change.

What is the evidence?

Rogers and Daft, among others, have shown how the innovation process fails because of poor leadership and change management processes. Considerable work on healthcare teams has demonstrated the importance of team processes in determining the extent to which teams introduce new and improved ways of doing things. Examples have included breast cancer care, community mental health, primary care and executive teams.

When we think about how to stimulate innovation and quality improvement at work, leaders clearly have a powerful influence on the immediate social and psychological environment. If the work climate they create does not support innovation, staff who derive satisfaction from developing new and improved ways of working will become frustrated. Research has revealed that warm, supportive and flexible but intellectually demanding environments produce high levels of creativity and innovation.

Read the full summary here with guidance and tips.

Leading for quality improvement

SUMMARY

Quality improvement is crucial to the NHS's success. But individual projects are not enough to create widespread change: they must be underpinned by leadership that understands quality improvement processes and prioritises it at every level.

What is it?

Quality improvement (QI) involves designing and redesigning work processes and systems that deliver healthcare with better outcomes and lower cost. Examples range from redesigning how teams deliver care in clinical microsystems to large-scale reconfigurations of services such as stroke or cancer care. For this reason, Ham et al argue that QI must be understood, valued and enabled by the leadership.

Why is it important?

The NHS faces a huge test to improve patient care at a time of staff shortages and unprecedented financial challenges. "The English NHS cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy".

Following the Mid Staffordshire inquiry the principal recommendations in the Berwick report, A promise to learn, a commitment to act, were:

- staff focused on continually improving patient care
- staff focused on ensuring zero harm
- reflective practice and learning endemic
- all staff being accountable
- staff enabled at all levels to learn about best practice
- effective schemes to promote responsible, safe innovation (such as Lean and QI)
- recognition and reward for QI and innovation at every level and in every department, team or function.

What is the evidence?

A study of 16 US health systems found four factors critical for the success of effectively led redesign or QI initiatives:

- the direct involvement of senior and middle-level managers
- clear alignment between improvement initiatives and the organisation's priorities
- formal structures, processes and performance appraisal that enable feedback, learning and continuous improvement
- development provided for 'change champions', teams and staff leading the change.

Read the full summary here with guidance and tips

Secondments

SUMMARY

Secondments offer staff the opportunity to work in a different organisational type or culture, to broaden their experience and skills and share their learning.

What is it?

Secondments are one way to increase levels of engagement and boost motivation in individuals with high potential. They provide novel development opportunities that expose employees to different environments and experiences to those of their own organisation. Secondments provide developmental opportunities that take employees outside of the boundaries of their roles, grades, teams or even organisations.

Types of secondment may include:

- strategic assignments
- secondments to help resolve conflict between employees
- financially incentivised assignments.

Why is it important?

Developing leadership talent is integral to building an engaged, healthy and motivated workforce with the capability and capacity to deliver high quality, compassionate care. Offering individuals with high potential opportunities that nurture and challenge them will enable them to grow and flourish into high performing leaders.

In a knowledge economy, secondments are an excellent way of sharing expertise, speeding up innovation and fostering understanding between different organisations and different professions.

What is the evidence?

Successful managers report that they learn from challenging assignments, other people, hardships and coursework. These are the major sources of executive learning, which have led to the 70:20:10 formula (McCall et al 1988). This involves structuring leadership development initiatives around:

- on-the-job experiential learning (70%)
- enrichment by vicarious learning from others such as mentors, coaches, bosses and colleagues (20%)
- formal learning (10%).

Read the full summary here with guidance and tips

Developmental assignments

SUMMARY

Most of us typically learn through situations that arise naturally during our working lives. But this may leave gaps. Developmental assignments provide a more strategic approach, tailored to a staff member's needs.

What is it?

Developmental assignments come in many shapes and forms, but essentially are tasks to help an individual develop their skills. Developmental assignments are arguably the most useful learning experiences that leaders can have, if they are thought through and well structured. They may include key job challenges, such as:

- unfamiliar responsibilities – handling responsibilities that are new or different from previous responsibilities
- scope and scale – managing work that is broad in scope (involving multiple functions, groups, locations, products or services) or large in size (for example, workload, number of responsibilities)
- work across cultures – working with people from different cultures or with institutions in other countries.

Why is it important?

Leaders need to continuously refine their skills and acquire new capabilities throughout their careers to remain effective. Most leaders begin their careers with clear strengths that they bring to their work. But to be effective in a wide variety of leadership roles and situations, they have to master new skills in new areas. A significant part of this development takes place through practical experiences.

What is the evidence?

As well as learning from challenging assignments, other people, hardships and coursework, successful managers occasionally mention that a personal life event had an impact on the way they manage. These are the major sources of executive learning, which have led to the 70:20:10 formula.

Read the full summary here with guidance and tips

Action learning

SUMMARY

Action learning is a group approach to learning through a project, in which participants work together to identify and examine solutions to a real organisational challenge.

What is it?

Action learning is a project-based approach designed to develop discrete and manageable improvement opportunities for leaders and all staff.

The approach involves bringing together a group of leaders (or other staff) to address a known organisational issue or challenge. This provides a guided, integrative, real-time process that addresses complex challenges while developing individual, team and organisational capacity for leadership. It is a versatile organisational capability that, once developed, can be applied to a wide range of issues within the organisation or across a system.

The projects may range in size and scope:

- Small projects – Action learning projects may be short-term, limited in scope and aimed at those being developed, with some involvement from senior leaders. They are not necessarily expected to fundamentally transform how the organisation operates.
- Larger projects – They can be aimed at key strategic challenges and opportunities. In this case, they tend to broad in scope and ongoing – for example, managing the organisation's relationships with the local media or working across the sustainability and transformation partnership. They are aimed at transformation and learning for senior leaders, including the executive team. They are expected to fundamentally transform how the organisation operates.

Action learning builds leadership capabilities while addressing real business needs. Participants work in learning groups to identify and examine solutions to the organisation's critical leadership challenges. At the same time, they learn about leadership and development at the individual, team and organisational levels.

The organisation benefits from the resulting financial savings and new strategic plans developed during the action learning projects and the changes the participants make within their direct line of responsibility.

Action learning is different from traditional training, which involves:

- individual learning
- a focus on skill and knowledge acquisition
- teaching by experts using case studies and hypothetical situations.

In contrast, action learning involves:

- learning with coaches and other action learning team members
- a focus on behavioural and system change
- a focus on current organisational challenges
- learning at individual, team and organisational levels simultaneously.

Why is it important?

Action learning combines leadership development and organisation development in one seamless activity that strengthens leadership and improves organisational performance at the same time.

Because participants work in groups with others from across (or even outside) the organisation, the approach builds relationships vertically, horizontally and across boundaries.

The approach is strengthened by close attention to assessment, learning and capability development in addition to problem solving. It connects members of the senior team to other leaders across the organisation, providing senior leaders with first-hand exposure to others. Finally, it focuses on building individual leaders' capabilities as well as strengthening the organisation's collective leadership.

What is the evidence?

Successful managers report that they learn from challenging assignments, other people, hardships and coursework. These are the major sources of executive learning, which have led to the 70:20:10 formula. (To see more on this, go to Secondments)

Action learning projects are an ideal way to contribute to managers' experiential learning in a carefully structured way.

Organisations have reported the value of action learning programmes in solving problems, developing leaders, building teams and transforming their cultures over many years. However, little rigorous research has evaluated action learning. Leonard and Marquardt (2010) reviewed 21 refereed articles, theses and dissertations that measured its impact.

Read the full summary here with guidance and tips.

Action learning sets

SUMMARY

This approach involves learning in teams and applying new skills to real-life working situations to develop an integrated, experiential form of learning.

What is it?

Action learning sets are small groups of people who work together in a supportive and confidential learning environment. Participants identify a situation they want to change, then work alongside their colleagues to dedicate time and effort to tackle the challenge in a safe environment (Cumming and Hall 2001).

The fundamental aims of action learning sets are to help participants develop the skills and make time for reflection to solve their problems.

They create safe spaces that are ripe for problems to be shared, discussed, advised on and taken back to the workplace for testing and evaluation.

Why is it important?

Action learning sets give individuals the opportunity to learn through experience and reflection, in a team setting. They have been used across sectors and industries, both in leadership development programmes and in real work contexts. There are widespread reports of their value as an experiential learning process.

Action learning sets are especially important in the NHS, as they offer staff the space to reflect and learn from one another. This is particularly helpful for leaders who are likely to face unique yet comparable challenges. Action learning sets can be very effective, bringing leaders together to solve problems and learn.

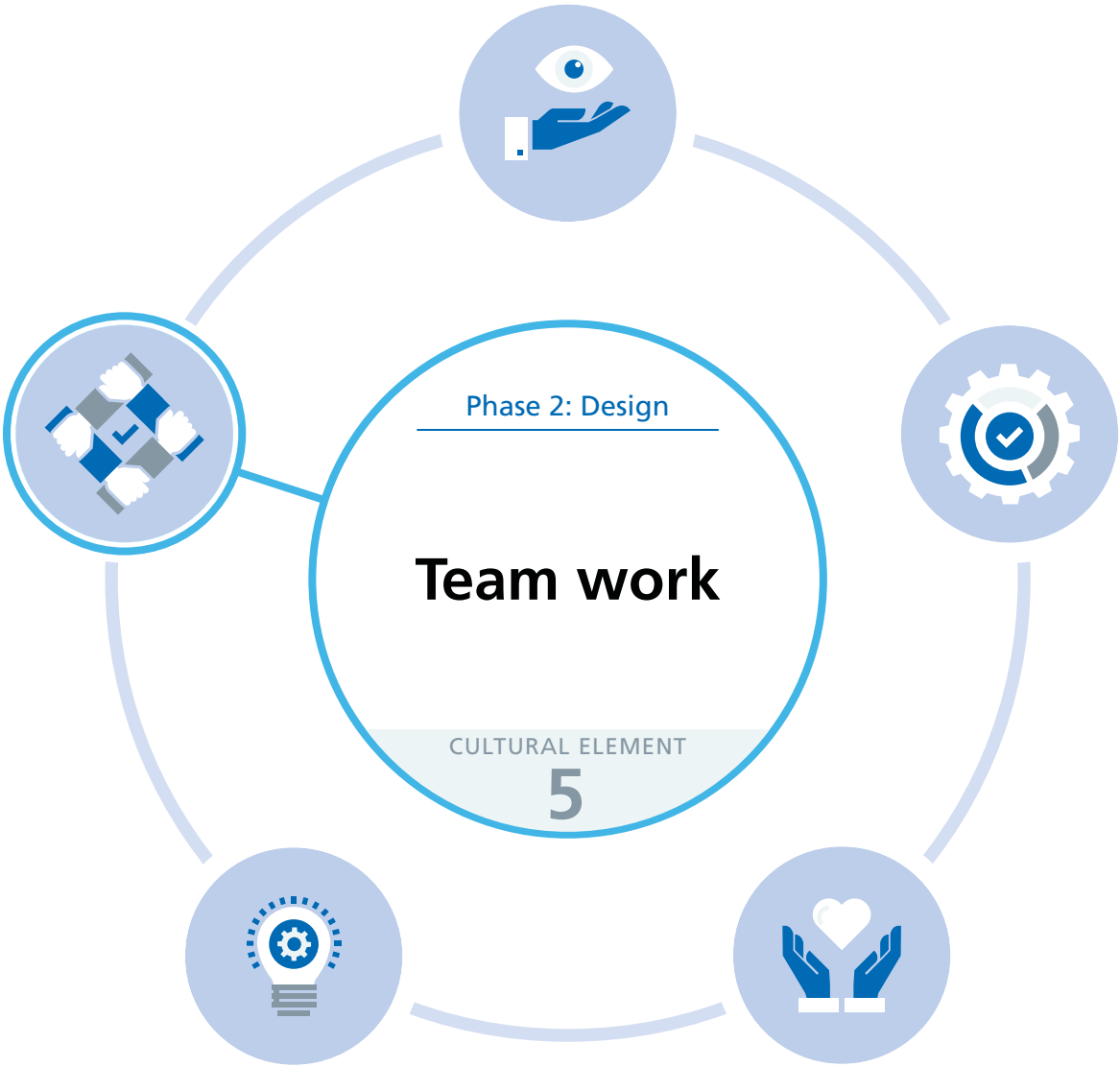
Because action learning sets often take place within the organisation, around real workplace issues, they are grounded in context. This makes them more likely to lead to tangible actions that result in real change and positive impact, for individuals and teams alike.

What is the evidence?

For individuals, benefits include having the opportunity to reflect, mindful thinking, suspension of evaluative judgment, the chance to practise giving and receiving feedback, and psychological safety. There are also multiple benefits for organisations.

Read the full summary here with guidance and tips

NHS Improvement



- Strategic recruitment for diverse teams
- Selection for team orientation
- Selection for team leadership capability
- Leaders developing leaders
- Executive team development
- Team leadership training
- Teamwork training
- Team-based appraisal
- Shared leadership in teams
- Ensuring clarity of team roles
- Team reflexivity and after-action reviews
- Building team-based working
- System leadership

Introduction

SUMMARY

Teamworking and co-operation across boundaries.

Teamwork is vital to healthcare quality. Healthcare staff must work together across professional boundaries to deliver high quality care, particularly as the complexity of healthcare increases (West and Lyubovnikova 2013, West and Markiewicz 2016). National staff survey data reveals that only 40% of NHS staff report working in real teams (that is, teams that have clear, shared objectives, which work closely together and meet regularly to review performance).

Within organisations, the more staff who work in this type of team, the lower the levels of errors, injuries to staff, harassment, bullying, violence against staff, staff absenteeism and (in the acute sector) patient mortality (Lyubovnikova et al 2015). Care quality and patient satisfaction are better too.

Inter-team and interprofessional collaboration are also fundamental to providing high quality healthcare (Richter et al 2006, West and Lyubovnikova 2013). The more teams work effectively together across boundaries, the better the quality of patient care. Where there are interprofessional rivalries, teams are unlikely to interact and share information effectively, with detrimental effects on patient care (Danjoux Meth et al 2009).

To achieve enthusiastic teamworking and co-operation across boundaries, leaders need to working collectively, adopting a common compassionate leadership philosophy in which they commit to:

- model compassion in dealing with patients and staff
- promote engagement, participation and involvement as their core leadership behaviours
- promote staff autonomy and accountability
- ensure staff voices are encouraged, heard and acted on
- encourage staff to be responsibly proactive and innovative
- take action to address systems problems that hinder staff from providing high quality care.

This need for co-operation across boundaries exists not only in different parts of an organisation. Increasingly, an interdependent network of organisations delivers healthcare. This means teams and leaders need to work together, spanning organisational boundaries both within and between organisations. It also requires each participant to prioritise overall patient care rather than the success of their component of it.

This requires a shared vision across organisational boundaries of:

- high quality, compassionate and continually improving care
- frequent and supportive contact across boundaries between leaders
- a long-term commitment to co-operative working
- quick, creative and fair resolution of conflicts
- orientation towards helping the other.

All these elements of cross-boundary working are fundamentally underpinned by compassion (Hulks et al 2017).

References

Danjoux Meth N, Lawless B, Hawryluck L (2009) Conflicts in the ICU: perspectives of administrators and clinicians. *Intensive Care Medicine* 35 (12): 2068–2077

Hulks S, Walsh N, Powell M, Ham, C, Alderwick H (2017) Leading across the health and care system: lessons from experience. The King's Fund, London Available at: www.kingsfund.org.uk/publications/leading-across-health-and-care-system

Lyubovnikova J, West MA, Dawson, JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24 (6) 929–950

Richter AW, West MA, van Dick R, Dawson JF (2006) Boundary spanners' identification, intergroup contact and effective intergroup relations. *Academy of Management Journal* 49: 1252–1269

West MA, Lyubovnikova JR (2013) Illusions of team working in health care

West MA, Markiewicz L (2016) Effective team work in health care In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

Strategic recruitment for diverse teams

SUMMARY

Teams need to be diverse to perform well – not just in their demographics but in skills and experience. So in a sector that depends on effective teamwork, organisations must recruit for optimum diversity.

What is this?

Making sure organisations recruit in ways that ensure appropriate diversity is extremely important, for performance and moral reasons alike. But it is not enough simply to ensure that recruitment and selection are appropriate. We may have a workforce that mirrors the community it serves, but many teams within the organisation may still be inappropriately homogenous. For example, a hospital executive team may be made up entirely or largely of men in a workforce where women constitute the large majority.

Strategic recruitment for diverse teams aims to ensure that at team level (particularly, senior team level), the degree of diversity is appropriate. This is not only an issue of demography: it addresses questions such as how similar to, or different from, each other team members should be.

Why is this important?

Because teamworking is so important to healthcare delivery and organisational performance, it is vital to think carefully about constructing teams. Usually, teams must be diverse to perform effectively (for example, in delivering high quality, continually improving and compassionate care). So recruitment processes must be designed to achieve appropriate diversity in teams.

What is the evidence?

If all team members have similar backgrounds, views, experiences and values, they are likely to quickly establish good relationships and work reasonably effectively as a team. Conversely, where team members are dissimilar, they are likely to find that early interactions are characterised by conflict as members try to understand each other and agree the objectives, leadership and roles in the team.

This might sound like a prescription for keeping teams as homogenous as possible. However, over time, a greater diversity of perspectives will offer a broad range of views and knowledge. This in turn produces better decision-making, more innovation and higher levels of effectiveness. This synergy is achieved by making a conscious effort to ensure effective, integrated teamworking.

Read the full summary here with guidance and tips.

Selection for team orientation

SUMMARY

High quality healthcare depends on good teamworking. These skills can be learned, but it helps to recruit people who are already oriented towards this style of working.

What is it?

If an organisation is to have effective team-based working, it needs to make sure staff are motivated and skilled to work in teams.

Selection for team orientation involves building into selection processes methods that provide information about people's knowledge, skills, abilities and motivations to work in teams. If it identifies people with a strong team orientation, you may choose to give preference to those candidates. If it identifies a learning need, it is useful to know that this needs to be addressed.

Selecting people with a high team orientation will lead to better team performance. Someone's orientation towards teamworking might include factors such as:

- a collective, rather than individualistic, approach to working with others
- social skills such as listening, speaking, and co-operating
- teamworking skills such as collaboration, concern for the team and interpersonal awareness.

Why is this important?

The NHS relies on effective teamworking. In turn, teamworking is strongly associated with high quality patient care. However, despite this, most NHS teams appear to be 'pseudo-teams', where individuals do not co-ordinate their work as effectively as possible, are often unclear about one another's roles and are not focused on clear, challenging interdependent team goals or objectives.

What is the evidence?

One theory holds that effective team functioning depends on teamwork knowledge, skills and abilities, divided into two broad areas: interpersonal and self-management. Several studies found that team members' scores related significantly to their teams' performance. A range of evidence also shows the links between high team orientation and performance, and identifies leadership qualities that increase team orientation.

Read the full summary here with guidance and tips.

Selection for team leadership capability

SUMMARY

Being an effective team leader requires different skills from other types of leadership. If an organisation wants effective teamworking, it is worth assessing for these qualities as part of the selection process.

What is it?

Strong team leadership skills are vital for good team performance. So organisations need to focus on selecting people with the knowledge, skills, abilities and values for teamwork in general, and for leading teams in particular. They also need to support team leaders to continue developing their team leadership skills.

Selecting for team leadership involves understanding what the knowledge, skills and abilities for team leadership are, and then recruiting and selecting accordingly.

Why is this important?

Researchers have consistently pointed to the importance of leadership in determining teams' effectiveness over the last 10 years. Leadership in health services is important not just at the organisational level, but at the team level too. Leadership style has been associated with quality of care, clinical governance and patient complaints.

However, in health services, leadership is often poor. Only one-third of primary healthcare teams and one-tenth of community mental health teams reported having a single clear leader, and in nearly half of primary healthcare teams, members reported that several people led the team. Lack of clear leadership predicted higher stress levels among team members. Such conflict and lack of clarity are partly a result of appointing people to team leadership roles who do not have the necessary knowledge, skills, abilities or values.

What is the evidence?

Traditional leaders tend to be directive rather than facilitative and advice-giving rather than advice-seeking. They seek to determine rather than integrate views. In contrast, effective team leaders share responsibility for the team and encourage team members to take responsibility when things are not going well. They are less likely to exercise control over the final choice when decisions need to be made, and they tend to manage the team as a whole, as well as supporting individual team members.

Read the full summary here with guidance and tips.

Leaders developing leaders

SUMMARY

Encouraging senior leaders to act as mentors, role models and coaches is an effective way of supporting emerging talent and opening dialogue between senior leaders and their junior colleagues.

What is it?

Leaders developing leaders is a practice that focuses on using experienced leaders as in-house coaches, trainers and teachers in their own organisations to develop other leaders.

Why is this important?

Seasoned leaders (including those in non-leadership roles but with experience in the organisation) are uniquely positioned to role-model and share the leadership values, beliefs and behaviours that are important to develop in their organisation.

To be effective and efficient, initiatives to build a leadership pipeline (addressing core aspects of succession planning) need to develop not only leadership skills but an interconnected cadre of leaders with similar mindsets and values. The organisation benefits from a strengthened culture of learning and continuous development, laying a solid foundation for organisational innovation and quality improvement.

What is the evidence?

Research by the Center for Creative Leadership shows that high-performing companies have leaders who lead purposefully, to increase engagement, diversity and accountability.

Among these companies, a core leadership task is to develop other leaders through role modelling, teaching, coaching, mentoring, and active dialogue and reflection around the topic of leadership. They hold their leaders accountable for the promotion rate of people with high potential, have fully integrated diversity and inclusion goals for selecting and developing leaders, and have an overall mindset of leaders needing to connect with people and mobilise the talent of tomorrow.

Read the full summary here with guidance and tips.

Executive team development

SUMMARY

The executive team is the foundation on which the rest of the organisational culture is built. But a high functioning senior team does not emerge naturally: it must develop specific skills with an eye on the strategic vision.

What is this?

Executive team development involves supporting an organisation's executive (or 'senior') team to function effectively.

It involves making sure the senior team works as a real team towards clear, shared objectives, rather than simply as a group of individuals representing different functional areas. In particular, it focuses on:

- team structure ensuring the right purpose and the right membership for the purpose
- team processes team member participation, managing conflict, learning and innovation, and supporting innovation.

Senior team development interventions also ensure that relationships help the team to function effectively, creating a climate of cohesion, optimism and efficacy.

Why is this important?

The senior team plays a vital and pervasive role in determining an NHS organisation's effectiveness. Together its members decide strategy, shape the culture, scan the environment, monitor performance and, above all, support the organisation in pursuing its aims and achieving its vision. So, it is essential that it functions as well as it can.

The senior team is usually made up of those who have risen or fought their way to the top of their particular specialist areas. Precisely because of this individualism, bringing them together to work in a team can produce a competitive and dysfunctional group rather than a co-operative, integrated and supportive team (Flood et al 2001).

The effects of this dissonance can undermine integrated collaborative working and the climate across the whole organisation. Farrell et al (2005) and MacCurtain et al (2010) found that the more positive the senior team climate, and the greater the trust between senior team members, the more employees saw the climate as supportive and encouraging innovation and experimentation (see also Albrecht and Travaglione 2003).

What is the evidence?

The evidence shows that executive team development must focus on team structure (including the team's 'task' or purpose and membership), processes and relationships.

Read the full summary here with guidance and tips.

Team leadership training

SUMMARY

Team leadership in healthcare is often poor, despite the importance of teamwork in the sector. This is partly because leading a team requires a particular set of skills. Tailored training for team leaders can address the gaps and give organisations the best chance of delivering high quality care.

What is this?

In organisations where work is structured around teams, it is important that leaders understand and put into practice the principle of leading in teams and team-based organisations. Team leadership training therefore focuses on making sure leaders have the knowledge, skills and abilities to develop and structure teams, facilitate and maintain healthy team processes and develop positive team climates and relationships.

It is equally important to understand how to develop and maintain co-operative, supportive and effective inter-team working processes. Team leadership training focuses on providing leaders with the knowledge, skills and abilities to be effective team leaders in team-based organisations.

Why is this important?

Team leaders influence co-ordination, creativity, knowledge-sharing, problem management, actions, affective tone (for example, whether there is a positive or negative climate), efficacy, empowerment, potency and commitment to the team and the organisation. However, in healthcare organisations there are some key tripwires for team leaders that may jeopardise team performance and, in turn, service delivery.

What is the evidence?

Over the past 10 years researchers have consistently demonstrated the importance of leadership in determining the effectiveness of healthcare teams, yet leadership is often poor.

Team leaders need to be trained to ensure that teams regularly take time out to review what they are trying to achieve and how they are going about it. Those who do this lead teams that are much more effective and much more innovative in delivering patient care.

Read the full summary here with guidance and tips.

Teamwork training

SUMMARY

Healthcare must operate around teams. The most successful organisations acknowledge this and encourage a team-based culture, supported through training in the specific skills that this approach requires.

What is this?

Teamwork training focuses on developing the knowledge, skills, abilities and values that underlie teamwork competencies. It also focuses on ensuring good communication, co-ordination and collaboration in healthcare teams and supporting the transfer of training to the work environment.

Why is this important?

The link between teamwork and clinical outcomes has been demonstrated across a range of contexts, including intensive care units, operating rooms, nursing homes, accident and emergency departments, maternity suites and surgical wards. However, although teamwork is vital for high quality healthcare, the quality of teamwork in the NHS is often poor. This leads to:

- errors that harm staff and patients alike
- injuries to staff
- poor staff wellbeing
- lower levels of patient satisfaction
- poorer quality of care
- higher patient mortality.

Research also shows that quality of teamwork predicts the extent to which teams develop and implement innovation in healthcare, such as introducing new and improved treatments for patients or methods of delivering care.

What is the evidence?

Teamwork in healthcare is often highly dynamic, with people participating in multiple teams and on an ad hoc basis, compared with intact teams that work together over a sustained period of time. Reviews reveal that regardless of whether the team is ad hoc or intact, the effects of teamwork training are similarly positive.

Read the full summary here with guidance and tips.

Team-based appraisal

SUMMARY

This approach to appraisals focuses on the performance of teams, with individuals appraised by fellow team members to emphasise team-based working throughout an organisation.

What is it?

In team-based organisations, appraisals are regularly carried out on teams, rather than individuals. These team appraisals include:

- reviewing the appropriateness of the team task and making sure it is aligned with the organisation vision
- assessing team performance, based on input from individuals the members report to and work with (including patients and other teams within the organisation)
- asking how the team's work could be more challenging, rewarding, engaging and powerful in contributing to the overall mission of the organisation.

Why is it important?

There is general understanding in the NHS that good teamwork is vital for good healthcare but a lack of attention to ensuring the quality of team working in the NHS. This poor team-working leads to higher levels of errors, injuries to staff, stress and avoidable patient deaths.

Team-based appraisal is important because it ensures that organisations that intend to develop, maintain and support team-working are not then (paradoxically) structured around individual performance. If teams are seen as the key to performance but organisational systems are geared towards managing individuals, the organisation will be less effective.

What is the evidence?

There is considerable evidence of the importance of team working to healthcare, and to the performance of healthcare organisations generally. Indeed, the accumulation of evidence within the NHS over the past 30 years about the importance of teamwork to healthcare is unique worldwide.

Read the full summary here with guidance and tips.

Shared leadership in teams

SUMMARY

In organisations that emphasise a team-based approach, leadership becomes a collective activity depending on who has the most relevant skills for the task at hand, rather than based on hierarchy or status.

What is it?

Shared (also known as 'collective') leadership in teams means everyone taking responsibility for leadership, depending on the situation, the task, their skills, motivation and the context. There may be a formal hierarchical leader, but everyone in the team believes they play an important role in the leadership of the team, taking collective responsibility for making sure the team is successful in its work, functions well and supports the development and wellbeing of all team members.

Why is it important?

Given the challenges health services face in delivering care for patients, it is vital that all team members apply their knowledge, skills, and their capacities for co-operation and co-ordination within teams and across boundaries. This is essential for developing or implementing new and improved ways of delivering services, promoting efficiency, improving quality or providing patient care.

Creating the right conditions for innovation involves giving frontline teams the autonomy to experiment, discover and apply new and improved ways of delivering care. Teams are most likely to meet their capacity for innovation when their members are given discretion, control and freedom, and when they sense their responsibility for service improvement.

In this model, leadership becomes more of a collective endeavour than a designated hierarchical status that reflects an organisational chart.

What is the evidence?

There is much evidence that shared leadership in teams consistently predicts team effectiveness – particularly, but not exclusively, within healthcare. Shared leadership in teams creates a culture that is more likely to deliver high quality, compassionate care. This is because all team members accept the distribution and allocation of leadership power to wherever the expertise, capability and motivation sit in the organisation.

Read the full summary here with guidance and tips.

Ensuring clarity of team roles

SUMMARY

Role clarity means team members being clear not only about their own role but also about the roles of their colleagues. This understanding enables team members to be collectively motivated, aligned and effective in their work.

What is it?

When people work in teams, there is a danger that not everyone will work effectively, because of poor team processes. Ensuring accountability for teamwork can reduce this risk by clarifying the roles of team members. Doing this involves creating conditions that ensure that team members take responsibility for their own performance and for the performance of the team by ensuring:

- clear team objectives
- clear roles for team members
- regular reviews of performance.

Why is it important?

For teamwork to be effective, each individual needs to know how to function as a team member and must understand their responsibility for ensuring the effectiveness of the teamwork overall. A principal assumption behind the decision to structure an organisation around work teams is that teams make better decisions than individuals working alone.

What is the evidence?

The key to ensuring accountability for teams is to ensure clarity of team objectives and team roles.

When roles are clear, team members are more motivated, less stressed and perform better. Role ambiguity and role conflict are key factors in the development of work stress. When objectives and roles are clear, teams perform significantly better, with fewer errors, greater productivity and higher levels of innovation.

Read the full summary here with guidance and tips.

Team reflexivity and after-action reviews

SUMMARY

Team reflexivity involves teams stepping back to review their objectives, strategies, processes and performance and make changes accordingly. This practice leads teams to be more productive, effective and innovative.

What is it?

Team reflexivity involves team members collectively reflecting on the team's objectives, strategies and processes, as well as their wider organisation and environment, and adapting accordingly. There is increasing interest in this approach because it is an effective way of developing teamwork generally.

Reflexivity includes the concept of after-action reviews. These are reviews of specific team performance events or episodes to encourage reflection and self-discovery, target potential opportunities for improvement, and thus improve the quality and rate of learning.

Why is it important?

One of the challenges for healthcare teams is very high workloads which mean that teams need to be even more committed to taking time for regular reviews, to ensure their effectiveness.

When team members collectively reflect on the team's objectives, strategies, processes and performance and make changes accordingly ('team reflexivity'), teams are more productive, effective and innovative. In contrast, non-reflexive teams show little awareness of team objectives, strategies and the environment in which they operate. Instead, they tend to rely on habitual routines that ultimately lead to poor performance, lack of innovation and inability to adapt to a changing environment.

This is particularly important for staff working in the NHS, given that the majority of medical errors are attributable to poor teamwork. Most of these errors could be avoided if team members made time to communicate important information, share errors and reflect on ways to improve.

What is the evidence?

Growing evidence over the past 25 years shows that teams are much more effective and innovative in delivering patient care if they regularly take time out to review what they are trying to achieve, consider how they are going about it, and adapt their objectives and processes accordingly.

Read the full summary here with guidance and tips.

Building team-based working

SUMMARY

Team-based working involves working within and between teams. This is especially important in healthcare organisations where teamwork is essential for integrated, high quality care.

What is this?

Team-based working is an approach to organisation design based on structuring work primarily around, and between, teams. In team-based organisations, teams rather than individuals make decisions, at the closest possible point to the service user, client or patient. For this, an organisation must support team and inter-team working in its culture and in its key organisation development and people management processes.

Why is it important?

Teamworking in healthcare is often taken for granted, because teams and groups of teams must work interdependently to provide high quality care. However, we know that the quality of team and inter-team working in the NHS is often poor.

Establishing and developing team-based working is important precisely because many teams are dysfunctional and failing in the NHS. By identifying the causes of these failings, we can demonstrate how to develop proper team-based working.

What is the evidence?

Extensive research over 30 years has identified the value of team-based working for patient outcomes and staff wellbeing. Building effective team-based working is associated with:

- reduced staff turnover, absence and stress
- fewer errors and injuries
- less bullying, harassment and violence against staff.

It is also associated with better quality care and significantly lower patient mortality.

Case studies of organisations with team-based working reveal many benefits to organisational performance and patient outcomes.

Read the full summary here with guidance and tips.

System leadership

SUMMARY

This approach involves leaders taking a strategic view of entire health systems, working alongside leaders from other organisations or sectors to find common ground and develop cultures and objectives aligned across organisational boundaries.

What is this?

System leadership involves leaders working across boundaries within and between organisations and sectors, to ensure high quality integrated care and support for the communities they serve. This type of leadership requires specific skills, founded in cross-boundary working, compassion and understanding of how to build belonging and trust.

Why is it important?

Compassionate leadership cooperation across boundaries is not only needed within individual organisations. Governments, practitioners and policy-makers increasingly agree that health and social care services must be integrated to meet the needs of patients, service users and communities efficiently and effectively.

So as healthcare is delivered by an interdependent network of organisations, leaders must work together, spanning boundaries both within and between organisations, prioritising overall patient care rather than the success of their component.

What is the evidence?

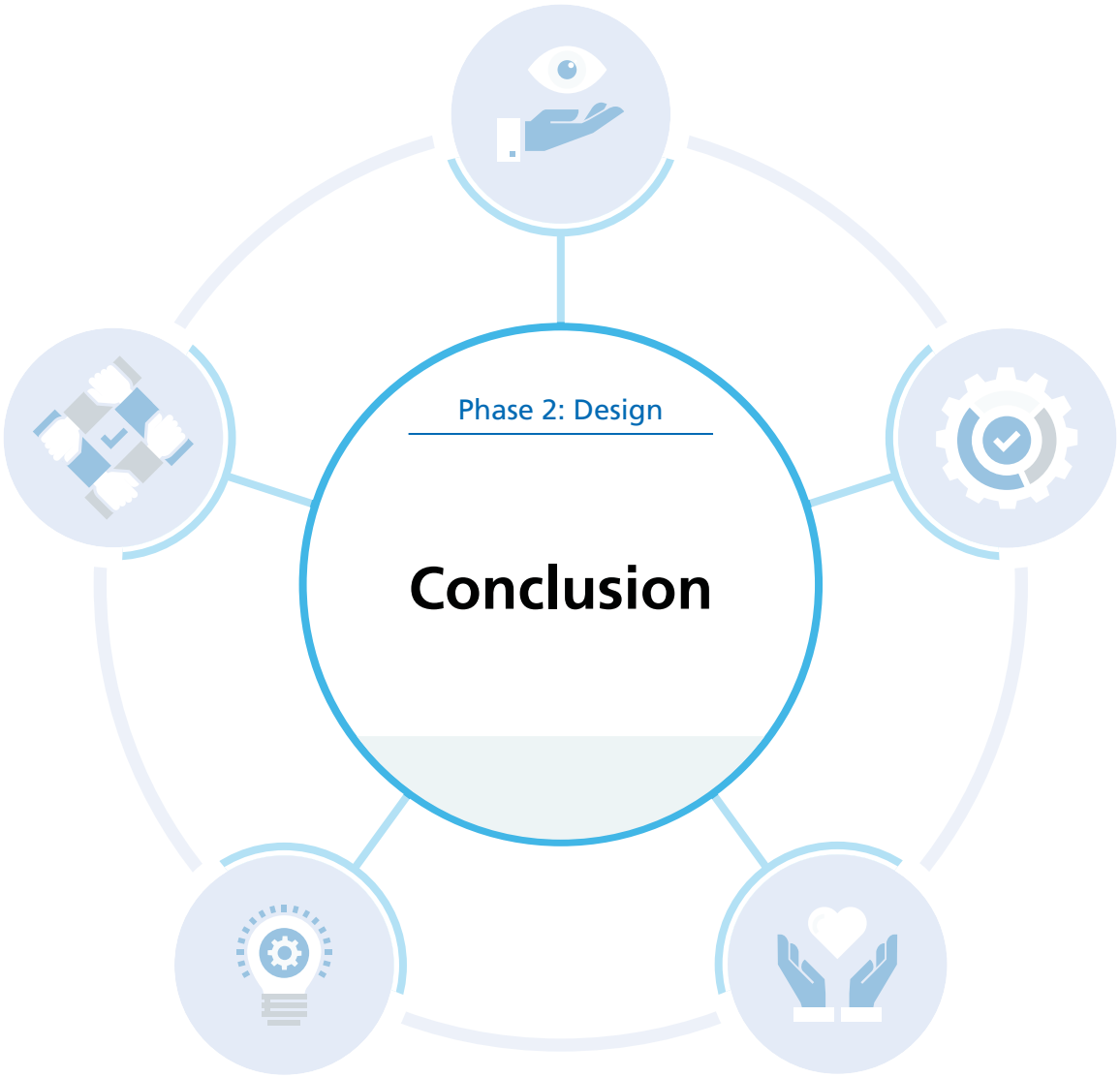
The evidence points to practical ways in which leaders can work together, across boundaries, to address challenges. It includes The King's Fund's work on:

- developing new care models
- sustainability and transformation plans
- accountable care organisations.

It is also informed by The King's Fund's work on the experience of people who have occupied system leadership roles.

Read the full summary here with guidance and tips.

NHS Improvement



Phase 2: Design

Conclusion

Moving on to Phase 3

Engaging and communicating the strategy

The test of any strategy hinges on how thoroughly it is implemented and its subsequent impact. This needs ongoing engagement and communication with the workforce and the board. For example, Lancashire Care NHS Foundation Trust set up cross-directorate 'task and finish' groups to orchestrate the work while the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust is enhancing its change champions' role by enabling some to pursue staff engagement activities and others to become more involved in project work associated with the implementation phase.

Evaluating Phase 2 Design

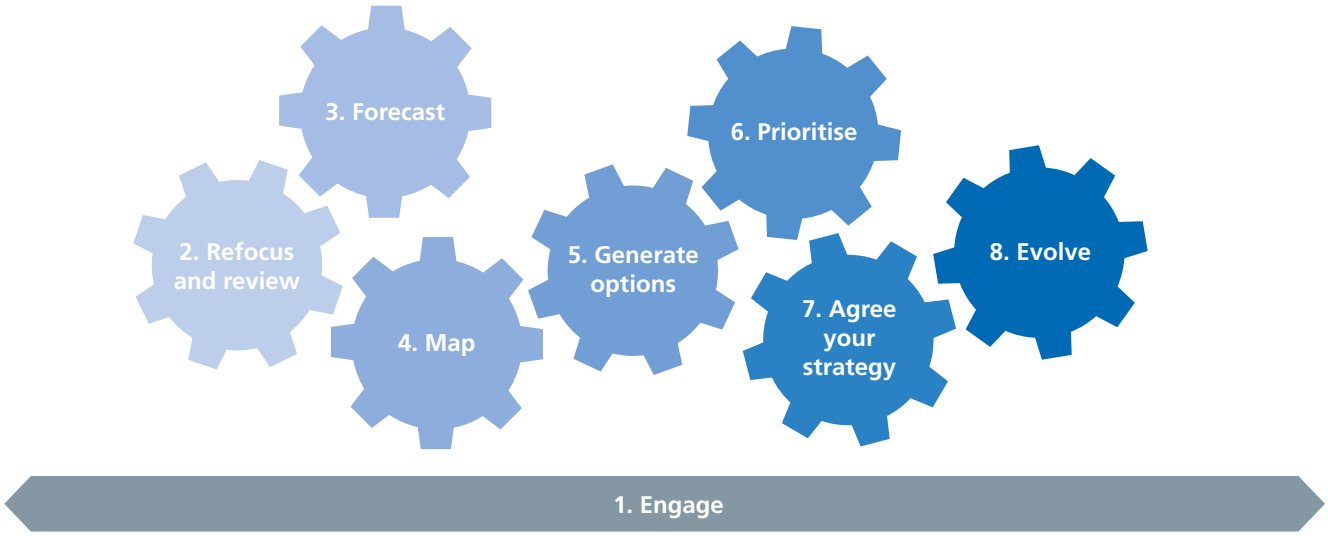
During Phase 1 you created an evaluation plan that you should have revisited at the beginning of this stage. Changes in the staff survey data and metrics in the culture and outcomes dashboard may now be apparent, and it could be tempting to draw conclusions from these about how well Phase 2 is working. But it is too early to fully evaluate Phase 2, though you can evaluate the learning and process of reflection for the change team. (Phase 1 toolkit)

Preparing for Phase 3 – Deliver

Phase 3 will help you deliver your compassionate, inclusive leadership strategy by implementing the actions you prioritised at the end of Phase 2. As well as requiring continued engagement from the board and wider workforce, this phase will fundamentally be about sustaining change. We will release resources to support this work during 2018.

The figure below, based on NHS Improvement's strategy development toolkit shows the steps of strategy development and how they interact.

Strategy development steps



NHS Improvement

EVIDENCE & SUPPORT

Vision & Values

- Values-based recruitment
- Values-based appraisal
- Values-based induction and transition
- Succession planning
- Values-based curricula
- Annual talent cycle
- *Case Studies*

Goals & Performance

- Leader role job design
- Inclusive recruitment
- Regular leadership forecast update
- Goal setting and goal review
- Setting and using team goals
- Providing feedback on behaviour and performance
- 360 degree feedback
- Measuring compassion
- *Case Studies*

Support & Compassion

- Compassion-based recruitment
- Developing compassionate leadership
- Developing emotional intelligence
- Inclusion: listening to all voices
- Coaching
- Mentoring
- Inclusive leadership development
- Diversity and equal opportunities training
- Compassionate behaviour training
- Identity-based talent management
- *Case Studies*

Learning & Innovation

- Developing cultures of innovation
- Leading for innovation
- Recruiting for commitment to innovation and quality improvement
- Development for managing innovation
- Leading for quality improvement
- Secondments
- Developmental assignments
- Action learning
- Action learning sets
- *Case Studies*

Team work

- Strategic recruitment for diverse teams
- Selection for team orientation
- Selection for team leadership capability
- Leaders developing leaders
- Executive team development
- Team leadership training
- Teamwork training
- Team-based appraisal
- Shared leadership in teams
- Ensuring clarity of team roles
- Team reflexivity and after-action reviews
- Building team-based working
- System leadership
- *Case Studies*

NHS Improvement

- Values-based recruitment
- Values-based appraisal
- Values-based induction and transition
- Succession planning
- Values-focused curricula
- Annual talent review cycle

Values-based recruitment

Values-based recruitment is a method of recruiting staff whose values are a good fit with your organisation's values while making sure the recruitment process communicates the organisational values to potential recruits at an early stage.

What is it?

Values-based recruitment (VBR) is a method of attracting and selecting employees whose personal values and behaviours align with the organisation's values.

Values are principles or standards that influence behaviour – literally, they are what we value, or what we judge as important in life.

Organisational values are the shared values of the key members of the organisation – particularly leaders, as well as the workforce in general.

Key values for high quality care

- Constant commitment to quality of care
- Continuous learning, quality improvement and innovation
- Support, compassion and conclusion for all patients and staff
- Effective, efficient, high quality performance
- Enthusiastic co-operation, teamworking and support within teams and across boundaries

Dixon-Woods et al (2014), West et al (2014)

Why is it important?

An organisation's values are fundamental to determining how people behave – in particular, whether the focus is consistently on ensuring high quality patient care. Most reports into NHS organisations' failings attribute them to culture and leadership – in other words, values.

The failings at Mid Staffordshire NHS Foundation Trust (Francis 2010) suggested that the organisational culture prioritised meeting regulatory requirements and managing costs at the expense of quality of care and compassion. The rise in deaths and appalling treatment of patients shocked the public. The resulting enquiries revealed leadership failures at every level of the health system. Organisational culture was highlighted as a key cause of the problems (Berwick 2013, Francis 2013).

Values-based recruitment seeks to make sure that staff have not only the right skills but the right values to deliver high quality patient care and experience.

Taking a proactive approach to maintaining consistent values across an organisation helps produces a strong culture that impacts on the outcomes that matter (West et al 2014).

What is the evidence?

Values-based recruitment is an emerging method, and to date, there is limited academic evidence about its effectiveness and the best ways of doing it. But there is ongoing evaluation by bodies such as Health Education England (HEE), which has developed a national VBR framework to help ensure that students and employees recruited to the NHS match the values of high quality care organisations.

www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment/tools-for-vbr/hee-vbr-framework

Selection practices in many healthcare professions tend to focus on technical or academic skills, yet research shows that values are important for the delivery of high quality, compassionate care (Patterson et al 2014). This research suggests VBR should be one part of a multifaceted approach to embedding organisational values. It also requires organisations to address wider cultural factors that influence behaviour in healthcare organisations, such as workload pressures, poor leadership and staff support and development.

Anecdotally, organisations within and outside the NHS that have successfully implemented values-based recruitment report benefits such as:

- reduced agency spend and recruitment costs
- positive impact on staff turnover
- increased staff morale
- a more positive work environment
- staff feel more valued
- reduced sickness absence
- increased job satisfaction
- patients receiving the best care possible (HEE 2016).

Research has clearly revealed the importance of ensuring a fit between the values of the organisation and of new staff – so-called 'person–organisation fit.' The better the fit, the more committed a new employee is to their organisation and the longer they stay. This is especially true during periods of organisational change (Meyer et al 2010, De Cooman et al 2009).

Given the difficulties of attracting and retaining staff in the NHS, it is vital to use the recruitment process to emphasise the values that matter to staff generally and to the organisations that make up our healthcare system.

How does it work?

During recruitment, those responsible for making decisions need to identify the values the organisation is seeking to attract. They then explore those values in potential recruits in ways such as:

- pre-screening assessments
- interviewing techniques such as structured interviews, role play or responses to scenarios
- assessment centre approaches
- psychometric instruments
- situational judgement tests (SJTs).

SJTs are a tool organisations use to evaluate applicants' behavioural and cognitive abilities when introduced with hypothetical, daily work-related situations. Patterson et al (2014) suggest that SJTs have improved validity over other selection methods and can be used to explore the organisational values needed for positive NHS cultures. SJTs have been used since 2013 to screen 16,000 medical school graduates, informing their allocation to foundation programme places alongside a measure of academic ability. The SJT has proved a reliable, valid and appropriate method for foundation selection, with applicants reacting positively to the test.

In practice, this might involve adding to the interview questions such as those in the box below.

Examples of VBR interview questions

To test for commitment to high quality care: 'Tell us about a time when you were under pressure to cut corners in providing care and how you dealt with it.' Key criterion: maintaining a commitment to high quality care

To test for commitment to effective, efficient performance: 'Tell us about a time when you had an excessive workload and how you managed that to ensure effective performance.'Key criterion: prioritising to ensure best use of resources and making judgements about the key areas to focus on

To test for support and compassion: 'Tell us about a time when you worked with a patient in distress. How did you go about the process?'Key criteria: attending, understanding, empathising, helping

To test for commitment to learning and innovation: 'Tell us about an improvement or innovation that you have introduced in the workplace that you are proud of and how you went about getting it implemented.'Key criteria: persistence, enthusiasm, challenging status quo, winning support

To test for commitment to teamworking and collaboration: 'Give an example of a time when you encouraged and enabled collaboration between your team and another team or department.' Key criteria: working effectively across boundaries and prioritising patient care overall, not just within team performance

Tips

- Values-based recruitment works best where it is implemented effectively and comprehensively. In an interview, for example, this means making sure that much of the questioning focuses on values issues and plays a major role in determining selection
- Leaders need training in how to conduct effective values-based recruitment
- The more objective the approach to selection, the better. So where an organisation has good psychometric measures of values such as compassion, it makes sense to use them
- Structured interviews are much more effective than unstructured interviews, as are work sample tests (Schmidt and Hunter 1998) and scenarios to test for values (for example, asking 'How would you react in this situation?'). Recruitment is just one part of the whole employment journey. It must form part of an holistic approach that ensures values are embedded in all areas of employment practice, from training and appraisals through to organisational development.

References

Berwick D (2013) *A promise to learn – a commitment to act: improving the safety of patients in England.* Department of Health, London. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf (accessed 11 July 2017).

Dixon-Woods M, Baker R, Charles K, Dawson J (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety* 23 (2):106–115

De Cooman R, De Gieter S, Pepermans R, Hermans S, Du Bois C, Caer R, Jegers M (2009) Person–organization fit: testing socialization and attraction–selection–attrition hypotheses. *Journal of Vocational Behavior* 74 (1): 102–107

Francis R (2010) Francis Inquiry: report into Mid-Staffordshire NHS Foundation Trust. Department of Health, London

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Stationery Office, London.* Available at: www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry (accessed 11 July 2017)

Health Education England (2016). Values-based recruitment. HEE, Leeds. Available at: www.hee.nhs.uk/our-work/attracting-recruiting/values-based-recruitment (accessed 30 June 2017)

Meye JP, Hecht TD, Gill H, Toplonytsky L (2010) Person–organization (culture) fit and employee commitment under conditions of organizational change: a longitudinal study. *Journal of Vocational Behavior* 76 (3): 458–473

Patterson F, Zibarras L, Edwards H (2014) Values-based recruitment for patient-centred care. In Tate L, Donaldson-Feilder E, Teoh K, Hug B, Everest G (eds.) *Implementing culture change within the NHS: contributions from occupational psychology.* British Psychological Society, Leicester

Schmidt FL, Hunter JE (1998) The validity and utility of selection methods in personnel psychology: practical and theoretical implications of 85 years of research findings. *Psychological Bulletin* 124 (2): 262

West M, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1 (3): 240–260

West MA, Topakas A Dawson JF (2014a) Climate and culture for health care performance. In Schneider B, Barbera KM (eds) *The Oxford handbook of organizational climate and culture*, Oxford University Press: 335–359

Values-based appraisal

Values-based appraisals reinforce the core elements of culture in the organisation. They make sure everyone is clear about what is most important, and help people stay focused on the areas that will ensure organisational effectiveness for patients and staff.

What is it?

This values-based approach to appraisal is designed to ensure the appraisal process reinforces the organisation's values. It does this by making clear to everyone (regardless of seniority) that the main way their performance is evaluated is based on the extent to which they model the organisation's values.

Appraisals are conversations between staff members and their line managers that enable people to agree clear, challenging, measurable objectives for their work, focused on those areas that most contribute to the organisation's core purpose. These objectives are designed to lead to better performance, higher motivation and lower stress. They also help people identify areas for development and the support they need. They should enable staff to do their jobs more effectively and reinforce a feeling that they are valued by their organisation for the work they do.

An organisation's values comprise what its leaders and staff value in practice. These are not necessarily consistent with the organisation's stated values. For example, the value stated in a mission statement might be 'high quality care' but in practice this value as enacted by staff might take the form of attempting to conceal mistakes (for example, in a culture with high levels of blaming).

Values-based appraisal takes this approach one step further, by ensuring that the appraisal conversation is focused on those values that have most influence in ensuring that NHS organisations achieve their purposes of providing high quality, continually improving and compassionate care.

Key values for high quality care

- Constant commitment to quality of care
- Continuous learning, quality improvement and innovation
- Support, compassion and conclusion for all patients and staff
- Effective, efficient, high quality performance
- Enthusiastic co-operation, teamworking and support within teams and across boundaries

Dixon-Woods et al (2014), West et al (2014)

In practice, a values-based appraisal conversation involves:

- agreeing objectives aligned with core organisational values
- helping the staff member ensure their job performance is aligned with core organisational aims
- making sure they feel their efforts to implement the values in their work are recognised, valued and appreciated.

Why is this important?

Values-based appraisal is important for two reasons:

Standard appraisals are often ineffective. Effective appraisals are powerful and helpful conversations rather than tick-box processes. But most NHS staff indicate that their appraisal conversations do not involve agreeing objectives for their work and/or do not help them do their jobs better and/or do not leave them feeling valued and respected by their employing organisation (Dawson et al 2011).

Values are crucial to how we behave. Values define the culture of the organisation: 'the way we do things around here.'

What is the evidence?

Research has shown the importance of helpful appraisals in predicting patient mortality in the NHS acute sector. Hospitals that ensured staff had helpful appraisal conversations had lower levels of mortality (West et al 2002, West et al 2006).

Research using the NHS staff survey data (Dawson et al 2011) reveals:

- The quality of the appraisal conversation makes a significant difference to outcomes in organisations across all domains (mental health, community and acute trusts)
- In trusts where more staff report having useful appraisal conversations (agreeing objectives, feeling valued by the organisation and able to do their jobs better), subsequent levels of staff engagement increase
- Where fewer staff report having useful conversations, subsequent levels of engagement decrease – and engagement is the most influential factor in the staff survey in relation to trust performance, including quality of care, financial performance and staff wellbeing (Dawson et al 2011).

The implication is that poor appraisal conversations may be harmful to staff engagement. But although nearly 90% of NHS staff reported having an appraisal in the previous year, barely 40% reported having helpful conversations. 'Helpful conversations' were defined as agreeing objectives, feeling valued by their employing organisation and feeling they can do their jobs better as a result (Dawson et al 2011).

How does it work?

In effect, values-based appraisal involves managers applying the NHS values to their appraisals. One way would be to structure the appraisal conversation around these values. This comprises four steps:

Step 1: Agree objectives with the person in relation to each value dimension. This involves:

- discussing objectives in relation to high quality care (or, if the individual does not work directly with patients, some other parameter)
- setting objectives relating to improving the effectiveness and efficiency of performance
- agreeing objectives around support and compassion in all interactions
- identifying ways of improving quality and innovating
- improving team and inter-team or inter-systems working.

Step 2: Explore what support they need or what barriers should be removed to help them do their job more effectively in relation to each value dimension. This might relate to work overload that hinders quality of care, or hierarchies and inter-departmental tensions that prevent attempts to introduce helpful innovations.

Step 3: Review their development needs in relation to each dimension such as quality improvement skills.

Step 4: Provide support for development in relation to each value dimension – for example, offering training in mindfulness and compassionate leadership.

Measuring data

If the appraisal includes performance data, the most common way of collecting this is through simple rating scales. This involves breaking down performance dimensions into their constituent parts, and asking raters (for example, fellow team members or patients) to indicate their judgements about the person's performance according to the scale.

Sample value-rating scale:

This staff member is compassionate in dealings with other staff members

The results can be skewed by the biases that raters bring to assessment, such as stereotyping, and the 'halo versus horns' and 'similar-to-me' effects (Woods, West 2015). These risks can be reduced by:

- training raters to be aware of their potential bias
- using multiple raters, including supervisors, peers, subordinates, patients or clients
- using behavioural scales, which involves asking the rater whether the person demonstrates particular behaviours, and with what frequency. Examples include behaviourally anchored rating scales (BARS) and behavioural observation scales (BOS) (Woods and West 2015)
- using a results-based appraisal method, where employee performance is judged based on what they achieve rather than how they behave.

Tips

- Make sure everyone who carries out appraisals has training (including role play) in how to ensure values-based appraisal conversations
- Allocate sufficient time and space for helpful conversations
- Invite staff members to come prepared for the conversation, bringing their own thoughts and proposals for their objectives and aspirations for the future
- Make sure the conversation covers success and difficulties in relation to objectives in the previous year
- Review aids and barriers to effective performance and identify ways to reinforce or remove them. Focus particularly on:
  - » factors that aid or inhibit the person from achieving success
  - » the line manager's role in aiding or inhibiting success, and what needs to change
  - » the person's developmental needs and how to meet them
  - » the person's wellbeing and how the workplace can be improved to achieve high levels.

References

Dawson JF, West MA, Admasachew L, Topakas A (2011) *NHS staff management and health service quality: results from the NHS Staff Survey and related data.* London: Department of Health. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 7 July 2017)

Dixon-Woods M, Baker R, Charles K Dawson J (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety* 23 (2): 106–115

West MA, Borrill CS, Dawson J, Scully J, Carter M, Anelay S, Patterson, Waring J (2002) The link between the management of employees and patient mortality in acute hospitals. *The International Journal of Human Resource Management* 13 (8): 1299–1310

West MA, Guthrie JP, Dawson JF, Borrill CA, Carter M (2006) Reducing patient mortality in hospitals: the role of human resource management. *Journal of Organizational Behaviour* 27: 983–1002

West M, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1 (3): 240–260

Woods SA, West MA (2015) *The psychology of work and organizations.* Cengage Learning EMEA, Boston

Values-based induction and transition

Building induction and transition processes around organisational values enables staff to perform more effectively and helps them understand the vision and values underpinning the organisation's culture, to ensure high quality care.

What is it?

Each employee is on a career journey that will change over time. Each change, whether to a new role, team with organisation or simply a new way of working, is known as a transition.

Values-based induction and transition involve supporting new staff to successfully navigate their entry to the organisation and helping existing staff adapt and integrate into new situations with minimal stress and maximum growth and development.

Why is it important?

Arriving in a new organisation can be a challenging experience, so it is important that inductions provide the support, information and value focus that will enable new members of staff to fit in and work effectively from the start. Similarly, transitions to new roles are more effective when they are planned and managed well.

Managing inductions and transitions is an important part of minimising unnecessary stressors that could contribute to anxiety, stress or burnout.

Poorly managed workplace inductions and transitions have been described as 'trigger events' that knock staff off balance and interfere with their emotional wellbeing and their ability to perform effectively (Avolio and Hannah 2008). They are also likely to distract staff from focusing on the vision and organisational strategy and compromise overall quality of patient care.

Taking the time to support inductions and transitions effectively is important not only for individual performance, but for the organisation's overall performance , and for reinforcing the vision and values underpinning the organisation's culture.

What is the evidence?

Considerable evidence demonstrates the importance of well-managed inductions and transitions:

- Realistic job previews at induction reduce subsequent turnover dramatically (Bauer et al 2007)
- Inductions that reinforce the sense of 'value fit' between new staff members and their organisations aid the induction and transition process. The more that staff experience compassionate cultures focused on high quality care in their induction process, the more likely they will be to have that sense of 'value fit', and therefore be likely to stay with the organisation rather than leave (Meyer et al 2010, De Cooman et al 2009)
- Good progress has been made on developing effective strategies for socialising new staff into organisations (Fan and Wanous 2008)
- When new staff are placed in teams with a strong sense of optimism, efficacy and cohesion, their adjustment is much more effective than those who encounter cynicism, conflict and ineffectiveness. Moving into roles with opportunities to grow and develop, and where there is relatively high autonomy and discretion, is also associated with positive outcomes in terms of job performance, innovation and stability of tenure (Saks and Ashforth 1997)
- In one large-scale study of UK managers (including NHS staff), those who moved into jobs providing fewer opportunities for growth and development were more dissatisfied and stressed than those who became unemployed over the same period (West et al 1990)
- Pratt et al (2006) explored the transitions of doctors over a six-year period and found that employees with lower levels of job discretion (in other words, autonomy and opportunity to develop the role) reported having to adapt much more, increasing their levels of stress. This was particularly the case early in the careers of the clinicians in the study. The researchers encouraged human resource practitioners to provide greater opportunities for new and less-experienced employees to craft or customise their new roles, to promote better adjustment and higher levels of engagement.

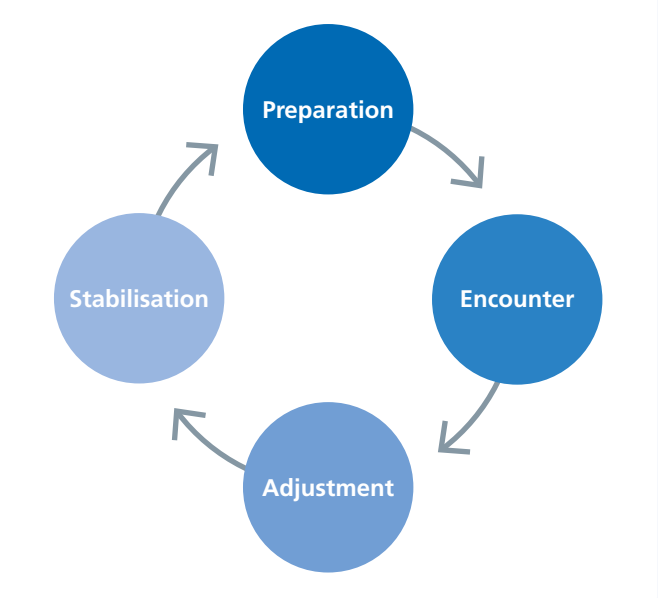
How does it work?

The success of inductions and transitions relies on:

- staff being consistently and persistently exposed to the organisation's vision and values in practice, not simply in rhetoric
- clear messages and guidance on the norms and practices in their new context
- integrating new employees from all backgrounds by promoting and valuing diversity and facilitating a culture of inclusivity and positivity
- managing the expectations and socialisation influences of the team that a new employee will be joining, to make sure the team aids the induction or transition process.

The transition cycle approach (developed by Nicholson 1987) is a helpful way of identifying four key stages of transitions and understanding the challenges that each stage presents. The summary diagram (right) draws on a detailed framework produced by Nicholson and West (1988).

The transition cycle



Tip: At every stage of the transition cycle, it is important that the organisation seeks to reinforce the values of high quality cultures (see Key values for high quality care).

Key values for high quality care

- Constant commitment to quality of care
- Continuous learning, quality improvement and innovation
- Support, compassion and conclusion for all patients and staff
- Effective, efficient, high quality performance
- Enthusiastic co-operation, teamworking and support within teams and across boundaries

Dixon-Woods et al (2014), West et al (2014)

Stage 1: Preparation/anticipation

This stage occurs before the person joins a new organisation or role (usually four to six weeks before taking up the role).

Aim of this stage	To achieve a state of readiness and have clear and realistic expectations of what is to come
Pitfalls	• fear, unreadiness, reluctance to change • exaggerated optimism, starry-eyed idealism
Strategies	Provide a realistic preview of the job, through induction packs or meeting the current staff member. After selection, offer more information on the role and team norms such as after-work socials or typical lunch times. Other approaches include: • self-appraisal (goals, needs) • advance contact with colleagues, supervisors and other team members • education and training to boost employee's confidence in the tasks to come • careers analysis and advice • systematic prior job analysis to identify key tasks and make sure these are communicated to the new employee in advance.

Stage 2: Encounter

This stage happens in the first few days or weeks in a new role.

Aim of this stage	To develop a sense of one's own competence to perform in the role and check the reality of the role against expectations
Pitfalls	• reality shock, bitter regret • defensive coping strategies (seeking group refuge, defensive hostility, withdrawal), quitting
Strategies	• Offer a climate of psychological trust and safety, with the team showing warmth and compassion, and adhering to the five values. The team needs to nurture and support their new colleague as they get to grips with their role. • Ensure the freedom to explore in the new environment without the pressure to perform or deliver, to avoid overwhelming. • Communicate well about operational criteria of 'effective performance' to ensure clarity about expectations. • Ensure social supports and regular check-ins with supervisors to manage initial concerns or surprises, built into the longer term to ensure that a positive and nurturing relationship develops between staff and manager. • Provide positive emotional orientation to help the employee approach change with optimism, eagerness and commitment rather than dread or anxiety.

Stage 3: Adjustment

This stage occurs after the employee has become more familiar with the organisation/role (usually in the first three to six months).

Aim of this stage	To conform to the role requirements, while actively innovating to shape the role to fit one's needs
Pitfalls	• a mismatch between the person and their environment • grieving for past or foregone opportunities • skills degrading or deteriorating with disuse
Strategies	• Emphasise the value the employee brings. • Highlight early successes through setting challenging tasks as well as easy wins. Tackling easier tasks early on will boost confidence and drive performance in more challenging tasks. Incrementally increase the degree of challenge, rather than throwing them in at the deep end. • Use swift, reliable feedback mechanisms to nurture a culture of feedback. This limits the extent to which employees internalise negative feedback and reduces interpersonal conflict by creating a channel for openness and transparency. • Treat failure as useful when it arises, to remove the fear of reporting errors and make employees more likely to seek help at the right time. • Use feedback and developmental strategies, in appraisals or informally, to keep employees engaged and aligned to their role-specific goals, supported by compassionate mentors and leaders who can listen and act on concerns. • Ensure that roles incorporate the space and flexibility for employees to craft their own job characteristics. This means employees can, within limits, take responsibility for shaping the role and more positively commit to it. • Use coaching or mentoring to help those moving into a new role to reflect on wider organisational issues, the strategic relevance of their roles and their learning and development.

Stage 4: Stabilisation

This final stage takes place when the employee is aware of organisational norms and has mastered their role. This usually occurs between six months and two to three years into the role.

Aim of this stage	For employees to perceive themselves as personally effective and to see how they are contributing to overall organisational effectiveness
Pitfalls	• underachievement, failure, 'faking good', fatalism • job becoming routine • boredom and reduced motivation
Strategies	• Set clear goals, negotiated via effective values-based appraisal, and support continual adjustment to the role requirements, to sustain effective performance. • Offer role redesign and encourage innovation to enhance people's commitment and provide a sense of continuing growth and development. • Construct and communicate a clear leadership succession plan, to help ensure that this stage is a positive springboard for future development. • Offer regular learning and development opportunities to ensure the person's continued growth, development and engagement.

Nicholson and West (1988) identify two key job characteristics that influence how well employees adjust during workplace transition:

- job novelty – how different the employee's new role is to their previous role
- job discretion – how much scope there is for the role to be modified by the employee. (In general, NHS leaders tend to give staff and teams too little discretion, inhibiting innovation.)

Tip: Emphasise transitions as opportunities for growth and development – particularly transitions that are unexpected and a consequence of restructure, merger or acquisition – to promote staff wellbeing.

References

Avolio BJ, Hannah ST (2008) Developmental readiness: accelerating leader development. *Consulting Psychology Journal: Practice and Research* 60 (4): 331

Bauer TN, Bodner T, Erdogan B, Truxillo DM, Tucker JS (2007) Newcomer adjustment during organizational socialization: a meta-analytic review of antecedents, outcomes, and methods. *Journal of Applied Psychology* 92 (3): 707

De Cooman R, De Gieter S, Pepermans R, Hermans S, Du Bois C, Caers R, Jegers M (2009) Person–organization fit: testing socialization and attraction–selection–attrition hypotheses. *Journal of Vocational Behavior*, 74 (1): 102–107

Dixon-Woods M, Baker R, Charles K, Dawson J (2014). Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *BMJ Quality and Safety* 23 (2):106–115

Fan J, Wanous JP (2008) Organizational and cultural entry: a new type of orientation program for multiple boundary crossings. *Journal of Applied Psychology* 93 (6): 1390

Meyer JP, Hecht TD, Gill H, Toplonytsky L (2010) Person–organization (culture) fit and employee commitment under conditions of organizational change: a longitudinal study. *Journal of Vocational Behavior*, 76 (3): 458–473

Nicholson N (1987) The transition cycle: a conceptual framework for the analysis of change and human resources management. *Research in Personnel and Human Resources Management* 5: 167–222

Nicholson N, West M (1988) *Managerial job change: men and women in transition.* Cambridge University Press, Cambridge

Pratt MG, Rockmann KW, Kaufmann, JB (2006) Constructing professional identity: the role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal* 49 (2): 235–262

Saks AM, Ashforth BE (1997) Organizational socialization: Making sense of the past and present as a prologue for the future. *Journal of Vocational Behavior* 51 (2): 234–279

West MA, Nicholson N, Rees A (1990) The outcomes of downward managerial mobility. Journal of Organizational Behavior 11: 119–134

West M, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1 (3): 240–260

Succession planning

Identifying future leaders can help ensure a sustainable workplace culture and consistent performance that continues beyond the current leadership's lifespan.

What is it?

Succession planning involves identifying, developing and reviewing potential leaders and managers to move into senior, significant or hard-to-fill positions, either in the short or long term.

Why is it important?

Making sure organisational values and vision are maintained and strengthened over time is fundamental to sustaining a culture of high quality, continually improving and compassionate care. Leadership is vital to this.

Even if a current staff member performs outstandingly, they will move on at some point. This could happen at any time – whether because of a role transition such as a promotion, an inter-organisational move, personal circumstances or illness. This is especially true in the dynamic environments of healthcare organisations.

Identifying potential successors as far as possible, and preparing them for future roles, ensures continuity and sustained performance. By ensuring consistency of leadership values over time, organisations can make sure they have the leadership skills, knowledge and attitudes they need to meet current and future challenges.

Tip: Given the widespread discrimination against minority groups in the NHS (West et al 2015), succession planning must reinforce principles of equality and diversity (including offering flexible working), to improve morale and performance. This helps secure leaders who represent the communities they serve, as well as their staff. Assessments need to be objective and scrutinised by senior leaders to ensure they are high quality, fair, compassionate and continually improving.

What is the evidence?

Research into succession planning suggests that the best organisations integrate leadership development and succession planning systems by:

- developing the organisation's mentor network
- giving potential leaders project-based learning experiences, to identify and develop possible candidates
- exposing potential candidates to a wide range of colleagues across the organisation
- maintaining a supportive organisational culture (Groves 2007).

Healthcare organisations often lack effective succession planning strategies. Research suggests this leads to problems with organisational performance (Blouin et al 2006).

How does it work?

Succession planning involves consciously and deliberately developing people's knowledge, skills and abilities through job experiences, leadership training and development activities that are aligned to the organisation's performance requirements, culture, values and vision.

As well as training and development activities, succession planning programmes include practical work experience that equips people to fill these roles when the current postholder moves on.

Four steps to succession planning

Step 1: Identify leadership positions and roles that will be most significant or difficult to fill.

Step 2: Identify potential successors, both in the shorter and longer term.

Step 3: Provide developmental experiences that reinforce values and develop knowledge and skills, such as job experiences, projects, secondments, coaching, mentoring, training and lateral job moves for the planned position or role. This may come in the form of a pool of potential successors who could move into several possible positions.

Step 4: Make sure that succession planning reinforces the core values of inclusion and compassion and developing leadership knowledge, skills and behaviours in areas identified in the diagnostic phase as critical for organisational performance – for example:

- facilitating shared agreement about direction, priorities and objectives
- encouraging pride, positivity and identity
- ensuring effective performance
- ensuring necessary resources are available and used well
- modelling support and compassion
- valuing diversity and fairness
- enabling learning and innovation
- helping people to grow and lead
- building cohesive and effective teamworking
- forging partnerships between teams, departments, and organisations.

Tips

- Integrate succession planning into the following related activities designed to recruit, develop and retain individuals, including the annual talent cycle to ensure continuity over time
- Work to retain and attract talent if you cannot find people within the organisation for key roles, you will need to attract outstanding applicants from other organisations. Succession planning can help you retain talented individuals by making them aware of internal opportunities to progress their careers
- To create a sustainable pipeline succession planning must go beyond immediate needs to identify future leadership positions and roles, based on the organisation and wider system strategies. It should be owned by those in key and hard-to-fill positions and their managers, and should also be vigorously led by the board and supported by HR, investing sufficient time to:
  - implement it effectively
  - integrate it with the values and desired culture of the organisation
  - ensure organisational commitment, from the board through all levels of leadership and management
  - train and educate leaders and managers to ensure high quality succession planning
- Align succession planning with the recommendations in Developing People Improving Care (a national framework for action on improvement and leadership development in NHS-funded services) in relation to talent management, to help integrate all areas of talent management.

References

Blouin AS, McDonagh KJ, Neistadt AM, Helfand B (2006) Leading tomorrow's healthcare organizations: strategies and tactics for effective succession planning. *Journal of Nursing Administration* 36 (6): 325–330

Groves KS (2007) Integrating leadership development and succession planning best practices. *Journal of Management Development* 26 (3): 239–260

West M, Dawson J, Kaur M (2015) *Making the difference: diversity and inclusion in the NHS.* The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

Further reading

Cannon JA, McGee R (2011) *Talent management and succession planning.* CIPD toolkit. 2nd ed. Chartered Institute of Personnel and Development, London

Church AH (2014) Succession planning 2.0: building bench through better execution. *Strategic HR Review* 13 (6): 233–242

Clutterbuck D (2012) *The talent wave: why succession planning fails and what to do about it.* Kogan Page, London

Davila N, Pina-Ramirez W (2014) Populate the pipeline. T&D 68 (2): 32–37

Jacobs K (2012) HR's role in executive succession planning. HR Magazine, 19 November. Available at: www.hrmagazine.co.uk/article-details/hrs-role-in-executive-succession-planning (accessed 11 July 2017)

Rothwell WJ (2010) *Effective succession planning: ensuring leadership continuity and building talent from within.* 4th ed. American Management Association

Sorensen A, Mlot S (2013) Human resources' role in succession planning. *Workspan* 56 (11): 38–41

Succession planning orientation guide (2013) *Workforce Management* 92 (3): 20–22

Taylor S (2014) *Resourcing and talent management.* 6th ed. Chartered Institute of Personnel and Development, London

9-Box Grid

The 9-box grid is an individual assessment tool that evaluates an employee's current contribution to the organisation and his or her potential level of contribution.

The 9-box grid is a simple table graph that rates potential on the Y (vertical) axis and performance on the X (horizontal) axis. So, the vertical columns of the grid identify an individual employee's growth potential within the organisation, while the horizontal rows identify whether the employee's performance is below, meeting or exceeding expectations in their current role.

How is it used

The 9-box grid can be used in a number of ways:

- Succession planning The 9-box grid is most often used in succession planning as a way of evaluating an organisation's talent pool and identifying potential leaders. In this case, the X-axis assesses leadership performance while the Y-axis assesses leadership potential. The combination of these two axes determines which box the leader is placed in, within the grid. Those who are placed in the top right of the grid (box 1) will be identified as high-potential candidates in the organisation's succession plan.
- Performance appraisal The grid provides a simple visual reference that can include appraisal and assessment data to allow managers to easily view employees' actual and potential performance. They can then design individual developmental plans for high- and low-performing employees, with collaboration from HR colleagues.
- In coaching and talent management Here, the value of the 9-box grid is to identify when an individual needs coaching or a change in job or responsibilities. The organisation may not choose to invest a lot of time and effort trying to support people with low potential and poor performance. However, an individual with low potential but effective performance may benefit from interventions to increase their engagement or motivation.

What is the evidence?

There is no empirical evidence of the value of this approach in the workplace, but its widespread use in organisations such as Deloitte and the US Society for Human Resource Management suggests its value.

Many find the 9-box grid a useful tool for their organisations, but it is a complex tool, and to reap the benefits it needs to be used correctly.

Readiness to move / **Performance and behaviours**	**Professional talent** Shows promise to continue to advance in their professional field or into a wider leadership role within 3–5 years if they have the capacity and ambition to do so, but equally valuable where they are.	**Developing talent, ready soon** Demonstrates the potential. ambition and motivation to develop at their current level and potentially progress in their career within 1–3 years into new and wider challenges	**Ready now** Demonstrates the potential, ambition, motivation and experience to perform at the next level now or within the next 12 months into new and wider challenges
Exceeds expectations Outstanding performance against objectives, achieves more than what is expected of them, and demonstrates role modelling of behaviours required beyond their role.	**Professional in field** • High performance in own field Role models behaviours of organisation/ role • Consistent results and brings added value to tasks given • Possible reached 'expert' stage in their career • Shows upward potential, but less ambition, likely to move on in the medium future, outside of own specialism • Emergent wider skills	**Key generalist (pivotal and flexible)** • High performance with consistency of results across a variety of assignments and brings added value to tasks given • Acts wider than professional background • Role models behaviours of organisation/role • Low–moderate potential/ambition to move on possible happy to stay in current position • Secondary pool to fill critical positions; perhaps move one level; likely to shift to key of high professional roles over time	**Role model** *(high potential to go further)* • A role model with the highest levels of performance, potential and ambition to move on • High performer, bringing added value to assignments with lots of potential and capacity for immediate advancement • Role models behaviours of organisation/role • Demonstrates mastery of current assignment • True organisations asset – role model • First call to fill critical positions
Meets expectations Meets the expectations for performance against objectives and behaviours required at the level for their role.	**Future professional in field** • Good reliable performance • Behaves professionally in line with role • Showing upward potential but less ambitious to move outside of field • Shows upward potential, but less ambition, likely to move on in the medium future, outside of own specialism	**Solid generalist** *(solid/adaptable)* • Good rounded performance • Behaves professionally in line with role • Meets expectations • Works wider than professional background • Some potential to do more in long term if ambition and development allows	**Future emergent potential** *(capacity for key roles)* • Individual with high potential • Good rounded performance • Behaves professionally in line with role • Has the capacity to be a consistent talent, or with stretch move to higher levels
Partially met expectations Below met expectations against performance objectives and behaviours required at the level for their role.	**Developing professional** *(needs stretching)* • Current low demonstration of performance ad behaviours required of role • Being supported to reach their potential • Maybe in the wrong role	**Developing generalist** *(needs stretching)* • Low performance but showing moderate potential over time outside of professional role • Being supported, needs pushing and stretching to reach full potential • Maybe bored, under-used or in the wrong role	**Transition employee** *(new to role, needs support)* • New to post or assignment • Have yet to demonstrate results, or high potential in a new position / development assignment • Future performance will allow assessment of where they align to the grid longer term

Reference: NHS Leadership Academy Talent Management Conversation tool

Find out more

www.leadershipacademy.nhs.uk/wp-content/uploads/2014/10/PH6023-Leadership-Academy-Talent-management-guide1.pdf

healthandcaretalentmanagement.hee.nhs.uk/hcls/talent-management-toolkit/nine-box-grid

www.shrm.org/resourcesandtools/tools-and-samples/hr-qa/pages/whatsa9boxgridandhowcananhrdepartmentuseit.aspx

www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/lums/cphr/talent-management-ti.pdf

www.bersin.com/lexicon/details.aspx?id=13134

Values-focused curricula and learning

Curricula in healthcare learning need to be underpinned by the core values that our staff must have to ensure high quality patient care.

What is it?

People across healthcare undertake training – from medical students and nurses to allied health professionals, managers and administrators. The curriculum or programme that each person follows will determine the way they carry out their work and the quality of care.

Values-focused curricula continually reinforce the NHS's core values, particularly those underpinning high quality care cultures. For this reason, we recommend that trusts advocate for curricula nationally and locally to be values-focused, and ensure that values are incorporated into their internal learning and development programmes.

Why is it important?

Values-focused learning reinforces the values underpinning high quality care from the start of people's training and careers. This equips today and tomorrow's NHS staff with the direction, alignment and commitment to the values essential for promoting the health of our communities. When we design training curricula for health and social care staff, we must make sure the core values of high quality care organisations run through them, from start to finish.

What is the evidence?

Three major programmes of study highlighted several qualities shown by leaders in the best-performing healthcare organisations:

- a study of cultures of quality and safety in the English National Health Service (Dixon-Woods et al 2013)
- Dawson et al (2011) involved analysis of NHS national staff survey data from more than 350 organisations surveyed each year from 2004 to 2011, sampling the national workforce of 1.4 million employees
- extensive data on the performance of healthcare teams amassed over a 30-year period of research in the NHS, showing the links between quality of teamworking and quality of care (Lyubovnikova and West 2013, Lyubovnikova et al 2015, West and Lyubovnikova 2013, West and Markiewicz 2016).

How does it work?

Based on the research above, anyone designing training and learning needs to incorporate these areas into all curricula and programmes:

Constant commitment to high quality care

Leaders in the best-performing healthcare organisations have a constant commitment to high quality care. They prioritise a vision and focus on high quality, compassionate care, providing clear direction for their teams and organisations. In the best-performing healthcare organisations, all leaders (from the board to the front line) made it clear that high quality compassionate care was the core purpose and priority of the organisation (Dixon-Woods et al 2013).

Effective, efficient, high quality performance

This is characterised by a focus on five or six clear, agreed, challenging and aligned goals and objectives for teams and individuals at every level, with helpful and timely feedback on performance. Training curricula should ensure a robust understanding of the objective-setting process.

Support, compassion and inclusion for all patients and staff

This area relates to people management, which is of particular significance for service sectors because of the well-established relationships between staff management, customer service satisfaction and financial performance, demonstrated in the commercial service sector (Schneider et al 2005, Yagil 2014).

Healthcare requires leaders to model good people management, fostering high employee engagement and wellbeing, enabled by supportive, positive, authentic, inclusive and compassionate leadership. The evidence suggests that where health service staff report that they are well led and are satisfied with their immediate supervisors, patients say that they, in turn, are treated with respect, care and compassion (Dawson et al 2011).

The annual UK NHS national staff survey data collected between 2004 and 2011 reveals significant insights into these relationships. The data shows significant links between staff experience and patient outcomes. Staff views of their leaders predicted patients' perceptions of their care quality. There was a strong relationship between staff satisfaction and commitment and patient satisfaction (Dawson et al 2011). The more positive staff were about their working conditions, the more positive patients were about their care. These relationships were confirmed in analyses of longitudinal data.

Overall, the data shows clearly that when healthcare staff feel their work climate is positive and supportive, as shown by coherent, integrated and supportive people management practices, care quality is simply much better (for example, there are low and declining levels of patient mortality in the acute sector). These associations are consistent across all healthcare domains: acute, mental health, primary care and ambulance.

Continuous learning, quality improvement and innovation

A commitment to continuous learning, quality improvement and innovation must be part of all national curricula. The evidence of the links between psychological safety, supportiveness, positivity, empathy, leadership (in aggregate, compassionate leadership) and innovation is deep and convincing (West et al 2017).

The landmark report by the Institute of Medicine, To err is human, led to a major movement in the United States to improve the quality and safety of healthcare (Kohn et al 2000). Applying lessons from sectors such as commercial aviation or nuclear power to healthcare offers the promise of enabling healthcare organisations to achieve levels of quality and safety comparable to those of the best high reliability organisations.

Chassin and Loeb (2013) recommend developing a strong culture of safety with the widespread use of effective process improvement tools. Compassionate leadership plays a key role here, in helping to promote a culture of learning that encourages risk taking (within safe boundaries) and accepts that not all innovation will be successful.

Enthusiastic co-operation, teamworking and support within and across boundaries

Research reveals that the more staff working in teams with these characteristics within an organisation, the lower the levels of errors, injuries to staff, harassment, bullying and violence against staff, staff absenteeism and patient mortality.

Given how fundamental teamworking is to quality of health and social care, curricula must provide staff with the basics of working effectively in teams and reinforce the value of co-operation and teamworking in healthcare (Lyubovnikova and West 2013, Lyubovnikova et al 2015, West and Lyubovnikova 2013, West and Markiewicz 2016).

It is also vital to ensure that the principles of good team leadership are well understood. Key team leadership skills should include:

- offering inspiring vision and clear direction
- ensuring regular and positive team meetings
- encouraging positive, supportive relationships
- resolving and preventing intense conflicts
- ensuring positive group attitudes towards diversity
- being attentive and listening (with fascination) carefully to team members
- leading inter-team co-operation
- nurturing team learning, improvement and innovation.

References

Chassin MR, Loeb JM (2013) High-reliability health care: getting there from here. *Millbank Quarterly* 91 (3): 459–90

Dawson JF, West MA, Admasachew L, Topakas A (2011) *NHS staff management and health service quality: results from the NHS staff survey and related data.* Department of Health, available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 12 July 2017)

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2013) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23 (2): 106–115.

Kohn LT, Corrigan JM, Donaldson MS (2000) To err is human: building a safer health system. National Academies Press, Washington, DC.

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. Salas E, Tannembaum SI, Cohen D, Latham G (eds). *Developing and enhancing teamwork in organizations.* Jossey Bass, San Francisco: 331–372.

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. E*uropean Journal of Work and Organizational Psychology* 24 (6): 929–950

Schneider B, Ehrhart MG, Mayer DM, Saltz JL, Niles-Jolly K (2005) Understanding organization-customer links in service settings. *Academy of Management Journal* 48 (6): 1017–1032

West MA, Lyubovnikova JR (2013) Illusions of team working in health care. *Journal of Health Organization and Management* 27 (1): 134–142

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds.) *The Oxford handbook of health care management.* Oxford University Press, Oxford: 231–252

West M, Eckert R, Collins B, Chowla, R (2017) *Caring to change: how compassionate leadership can stimulate innovation in health care.* The King's Fund, London. Available at: www.kingsfund.org.uk/publications/caring-change (accessed 12 July 2017)

Yagil D (2014) Service quality. Schneider B, Barbera KM (eds.) *The Oxford handbook of organizational climate and culture.* Oxford University Press, Oxford: 297–316

Annual talent review cycle

An annual review of staff performance and potential is a key part of succession planning in providing an informed approach to recruitment, talent management and leadership development.

What is it?

An annual talent cycle is a process in which managers and leaders review their staff's performance and potential. They then draw on this information to design leadership development, plan for succession and ensure their staff are supported to develop the knowledge, skills, attitudes and values they need to help achieve the organisation's vision.

A talent management system is an organisation's overall system for attracting, developing and retaining employees with the capabilities and commitment needed for current and future organisational success.

Why is it important?

All NHS organisations need to conduct an annual talent review because it will enable them to take informed and intelligent approaches to recruitment, talent management and leadership development.

A minority of NHS organisations believe they do not have the time or resources to engage in talent management, recruitment strategies and leadership development. The reality is that without a mature and informed approach to these issues, NHS organisations will not have the capacity and long-term resilience to respond to the challenges we face in delivering health and social care in the future. Recruitment, talent management and leadership development strategies are necessities, not luxuries.

What is the evidence?

There is some case study evidence that organisations that take a strategic approach to talent management by conducting regular reviews are more successful in performing well than those that do not (APQC 2004). More research is needed to identify what approaches to talent reviews are most successful (Lewis and Hackman 2006, Collings and Mellahi 2009).

How does it work?

Any organisation must be informed by data if it is to ensure that its talent review and recruitment, succession and leadership strategies are effectively addressing its needs. For this, it requires an annual talent review that includes the key metrics, as in Figure 1 below.

Quantity

- growth rate of new management positions in the organisation
- speed with which open positions are filled
- percentage of leaders seen as having high potential for promotion
- number of candidates for key leadership positions

Quality

- demographics of management population in the organisation
- demographics of those identified as high potential
- percentage of female and minority promotions
- percentage of positions filled internally

Knowledge, skills, attitudes and behaviours

- distribution of performance appraisal ratings
- group profiles on 360 degree feedback instruments
- involuntary turnover and demotions of managers
- job transition success rates

Culture impact

- results of organisation culture surveys, such as the Culture Assessment Tool
- national staff survey results
- reputation in the sector – for example, as a great place to work or employer brand
- ability to attract candidates generally as well as top candidates
- percentage of undesirable turnover and reasons for leaving

Figure 1: Key metrics

Key areas of need served by annual talent reviews

The talent review cycle is a key component of talent management. Three areas of organisational need are particularly served by talent reviews and leadership development:

Performance improvement

- Ensuring successful transitions – of leaders to new jobs and taking over the leadership of new teams
- Socialisation – reinforcing the vision, values and strategic narrative of the organisation, and making sure leaders are embodying the focus on the vision and values through their leadership
- Continuous learning – making sure leaders are engaged in ongoing self-improvement and reinforcing the importance of their constantly striving to improve their leadership

Succession management

- High-potential development – preparing leaders to successfully take on more senior leadership positions and increasing the flow of potential leaders in the organisation's leadership pipeline
- Successful transitions to new levels – helping leaders to learn and develop their leadership and knowledge, skills, attitudes and behaviours as they move to new levels in the organisation

Organisational change

- Support of strategic initiatives – developing leaders' ability to implement organisational strategies such as working collaboratively across organisational boundaries
- Adaptation to changing external conditions – making sure leaders have the capacity and knowledge, skills, attitudes and behaviours to lead in changing external contexts, such as dealing with the challenge of merging organisations.

How to do it

The talent review cycle is the process of reviewing leader effectiveness. The process needs to combine several methods, including these three:

- Talent reviews – Peer managers collectively review the performance and potential of all staff who report directly to them. A regular review shares knowledge about existing talent among all managers at appropriate levels. As well as providing valuable information about individual leaders, the reviews offer the opportunity to develop knowledge about the strengths and development needs of segments or particular communities of leaders (clinical directors, ward managers).
- Management team meetings – Ensuring senior managers' support for developing leaders is fundamental to the concept of a well-led organisation. When senior managers take on responsibility for leadership development and monitor, shape, nurture and develop the organisation's leadership, it has an enormous impact on organisational performance. Senior managers must pay attention to leadership quality as well as to quality of care, patient experience and financial performance. The quality of leadership across every part of the organisation should form a regular part of management team meetings.
- Leader development councils – In the most effective organisations promoting leadership development, usually a representative group of line managers meet regularly to ensure leader development aligns with needs and strategies and the service's operational realities.

The annual talent cycle does not adopt a generic approach to reviewing talent and planning recruitment, talent management and leadership development. Instead, it considers these organisational levels:

Social identity groups

Given the aspiration to ensure the NHS is inclusive, it is vital to prioritise gender, racial and cultural diversity of leaders in middle-to-senior management roles. This must lead to intensive recruitment, talent management and leadership development interventions to support people in groups that have experienced chronic discrimination in the NHS. This will help transform organisational leadership into inclusive and representative organisational leadership in the shortest possible time.

Differential investment in leader development by level

The total cost of leader investment may be higher at lower levels where there are more managers. But generally, per person investment is highest at more senior levels. You may have a strategic need to invest at a particular level, such as where cross-boundary working means that middle managers need to be trained to develop their collective partnering capacity.

Different targeted outcomes by level

Competencies at different levels, though some skills (such as compassionate leadership) may be common to all.

Different methods of development

Because there are more leaders at lower levels, leadership development at these levels is often more standardised – for example, all receiving the same training programme. Leadership development tends to be more customised (such as through individual coaching) at higher levels.

High potential status

Staff seen as having the ability, organisational commitment and motivation to rise to and succeed in more senior positions in the organisation are given particular consideration in terms of development opportunities. This might include:

- reserving key assignments for them
- matching them with outstanding leaders
- creating programmes to expand their networks of contacts
- engaging them in action learning teams
- providing opportunities for them to interact with senior leaders.

You may identify some high performing managers who are not seen as moving up the organisation but who are highly competent and mentor and coach others. It is important to make sure that they too continue to have opportunities to learn, grow and develop.

Functions, business units and locations

You will probably want to customise leader development for certain functions, units and locations.

Key methods of leadership development

- Developmental relationships including mentors, professional coaches, managers as coaches, peer learning partners, social identity networks (see identity-based talent management)
- Developmental assignments including job moves, job rotations, expanded work responsibilities, temporary assignments, action learning team projects
- Feedback processes including performance appraisal (particularly value-based), 360 degree feedback, assessment centres
- Formal programmes including leadership academy programmes, university programmes, skill training, personal growth programmes
- Self-development activities including reading, speakers, workshops and seminars, professional conferences, staff meetings

Tips

- It is important to define talent management broadly, while ensuring that you integrate the many elements of talent management into one comprehensive system. Talent reviews play a key part in this
- Make sure compassionate, inclusive and collective leadership behaviours are core to the talent review
- Use robust and rigorous methods for assessing and developing leadership capabilities
- Ensure that senior leaders on the executive team give strong support to the conduct of the talent review cycle
- Emphasise the links between talent review and your organisation's strategy
- Ensure the talent review leads to development for staff, and particularly those in under-represented groups
- Emphasise how talent review enables your organisation to attract and retain valued staff.

This summary was adapted from McCauley CD, Kanaga K, Lafferty K (2010) Leader development systems Van Velsor E, McCauley CD, Ruderman MN (eds) (2010) *The Center for Creative Leadership handbook of leadership development* (third edition). Jossey Bass, San Francisco: 29–62

References

APQC (American Productivity and Quality Center) (2004). *Talent management: from competencies to organizational performance*. APQC, Houston

Collings DG, Mellahi K (2009) Strategic talent management: a review and research agenda. *Human Resource Management Review* 19 (4): 304–313

Lewis RE, Hackman RJ (2006) Talent management: a critical review. *Human Resource Management Review*, 16 (2): 139–154

Additional useful resources

Further resources which will help your work in this area

NHS employers have a range of resources on values based recruitment including a readiness checklist, tools and case studies: www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment

Health Education England website on Values based recruitment includes a range of resources, including evidence, case studies and a link to an online tool at NHS Jobs: www.hee.nhs.uk/our-work/attracting-recruiting/values-based-recruitment

Skills for care have a toolkit on values based recruitment which also looks at embedding values in induction appraisal and supervision: www.skillsforcare.org.uk/Recruitment-retention/Values-based-recruitment-and-retention/Recruiting-for-values-and-behaviours-in-social-care.aspx

Health Education England, West Midlands and East Midland and the NHS Leadership Academy and NHS Leadership Academy East Midlands have produced this guide to Inclusive Talent Management: www.hee.nhs.uk/sites/default/files/documents/Inclusive-Talent-Management-Handbook-2014-Second-Edition.pdf

NHS employers also have a toolkit on People Performance Management which emphasises the importance of values in people management and has tips on induction and appraisal www.nhsemployers.org/case-studies-and-resources/2017/04/people-performance-management-toolkit

The NHS Leadership Academy has a talent hub which hosts useful resources on talent management including guides talent conversations and maximising potential: www.leadershipacademy.nhs.uk/resources/talent-management-hub/conversation/

Case Study 1

Who
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Programme name
Introducing values-based appraisal

What was the aim?

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) created its values in 2014 by consulting staff and patients. We need to embed these values in everything we do. We already had a communications plan in place so we decided to touch every member of staff during a one-year period by introducing a values-based appraisal.

Our appraisal process was of variable quality and completed inconsistently, with documentation varying in length. All appraisals were due to be completed on the anniversary of the employee's start date, so were spread across 12 months. They were not used to identify training needs consistently.

We therefore decided to introduce values-based appraisal.

What did they do?

We created our values and behaviour framework with an external company's help. We held focus groups with staff and interviews with board members to define good and poor behaviour for each of our four values and our overarching mission: "providing the excellent care we would expect for our own families".

The resulting behaviour framework has four layers:

- directors
- senior managers
- line managers
- staff.

We devised new appraisal forms and developed a one-day in-house appraisal training programme.

In the first year (2015/16) we introduced a new appraisal period from 1 April to 30 November with a target of 100% completion. We started training in February 2015. All appraisers for non-medical staff attended a full-day course and had to have their own appraisal before completing others' appraisals.

By the end of 2015/16 we had trained over 900 appraisers.

The new appraisal period met some resistance. The timetable created pressure on appraisers, but was intended to ensure staff were working towards common goals as early in the financial year as possible. We highlighted the evidence that good appraisal and improved patient outcomes are linked.

In the first year, feedback suggested that the forms were easier to use and the conversations of a better quality.

Our second year (2016/17) appraisal period ran from 1 April to 30 September with a 90% target. We appointed appraisal champions for each directorate, nominated and supported by their managers, to help the directorates in cascading their appraisals, reviewing quality and identifying training issues. We offered the champions development throughout the year (such as Myers Briggs Type Inventory) and how to challenge upwards, and asked them to become the 'eyes and ears' for our small organisational development team. We had three workshops with the champions and encouraged them to use action learning sets to share their experiences.

The appraisal champions' feedback from experiences and observations across the trust allowed us to make further changes for the third year.

What were the outcomes?

The new appraisal was significantly different in two ways.

Firstly, feedback was given not only on performance against objectives but on values-based behaviour – which was new to our managers. The one-day training programme spent a lot of time on the concept of giving useful feedback.

The second major difference was an attempt to align individuals' objectives with those of the team and the trust. Appraisers found this difficult. Most attending the training could not talk about their team objectives, and had no understanding of the trust objectives. In our new process, we asked appraisers to make the connections for individuals so they could see where they fitted into the wider trust strategy.

The main message from the appraisal champions was the Trust objectives were too remote and complicated for teams and individuals to identify with. The Board accepted this. The appraisal champions worked with our culture change champions and the Board to critique a first draft of the 2017/18 trust objectives. We reviewed the objectives from different staff groups' perspectives. Then the chair mandated our champions to finalise the objectives. We now have four simple overarching objectives that should be easy for teams and individuals to understand and see how they will contribute to achieving them. The champions said this has changed their perception of the Board.

The 2016 staff survey results showed a significant improvement, with 95% stating they had had an appraisal in the last 12 months and better quality discussions reported. However, there is still work to do on making the connection with our values, and using appraisals to identify and act on development needs.

What is the learning?

- Keep with it – We encountered many challenges, mainly around completing appraisals on time and meeting the 100% target. In Year 2 we set a more realistic target, but reduced the appraisal period. We aim to move to a three-month appraisal period from 1 April to 30 June to ensure all staff are aligned to the trust objectives each year as soon possible.
- Build a model of appraisal champions – Appraisal should not be owned by HR or OD but be a trust-wide initiative. By developing champions across the trust we encouraged collective ownership.
- Focus on quality as well as completion – By setting a completion target and appraisal period, appraisers felt under pressure to meet the target, which may have affected the quality of some appraisal discussions.

What next?

The 2016 staff survey results suggest we need to better connect appraisals and individual development needs. We need to review the types of development offered and how it links to the trust objectives.

We need to continue to help appraisers hold quality appraisal conversations. We are looking at options for refresher training (possibly online), using our appraisal champions to role model and educate. We also offer our line managers training in having difficult conversations as we introduce a feedback culture more widely.

We are introducing a focus on effective teamworking, using the Aston Team Journey, an online tool-kit for assessing current team performance and developing the areas of teamwork essential for success. This will help many of our newer managers to develop best practice skills in defining team and individual objectives.

Objectives for 2017/18

- Valuing our staff
- Improving quality and reducing harm
- Strengthening teamworking
- Listening to patients

For further information please contact:
Bridie.Moore@rbch.nhs.uk

Case Study 2

Who
Derby Teaching Hospitals NHS Foundation Trust

Programme name
Building excellence in care through compassionate leadership

Derby Teaching Hospitals wanted to put patient and staff views at the heart of its plans. By adopting compassionate leadership, the trust found that small changes can make a big difference.

What was the aim?

Our aim was to improve our Care Quality Commission rating from 'good' to 'outstanding'. Our chief executive understood that leadership would be central to this. We began a change programme, 'Collective leadership', based on the principles that 'everyone is empowered to be a leader' and 'everyone at every level leads and contributes to achieving high quality care'.

What did they do?

Phase 1: Discovery (0 to 6 months):
We recruited 15 LEAD (listen, engage, aspire and develop) ambassadors to the programme. They came from clinical and non-clinical backgrounds and included support staff, nurses, therapists, doctors and a patient representative. The project team gathered data on staff surveys (national, local) complaints and sickness and absence data, to take a snapshot of the trust's culture. We then ranked departments and teams as high, medium or struggling, and LEAD ambassadors conducted focus groups with a selection to explore opinions of leadership. More than 600 people took part. The ambassadors also interviewed executive and non-executive directors individually.

Phase 2: Design (6 to 12 months):
We identified the individual and collective leadership capabilities we required. LEAD ambassadors asked staff – in focus groups, roadshows, one-to-ones and internal conferences – what would create these capabilities. They asked:

- What would you like to keep?
- What would you like to develop?
- What do you need to make that happen?
- What doesn't work?
- How would you do things differently?
- What do you need to make this happen?

Phase 3 – Development (12 to 24 months):
Phase 2 recommendations helped shape the leadership vision and plan in this phase, which included:

- redesigning trust induction to initiate discussion about leadership at every level and leadership behaviours
- remodelling the appraisal process, emphasising leadership behaviours
- standardising presentations and tools to support collective leadership discussions
- creating a 'Developing our people' policy on providing development opportunities within the organisation.

What were the outcomes ?

The LEAD ambassadors' work is evolving and ranges from helping teams develop their leadership and/or engagement, presenting the collective leadership story at trust induction, together with the Top 10 leadership behaviours, and supporting staff engagement groups, to enhancing transformation projects with leadership support. The ambassadors meet regularly to continue their personal development and provide peer support. Recruitment of LEAD ambassadors is ongoing as their work is diverse and expanding.

Collective leadership in practice: working with the pharmacy department

LEAD ambassadors worked with the pharmacy department from the outset and evolved a bespoke support programme.

The discovery phase questions were:

- What does good leadership look like?
- What does leadership look like within this organisation?
- What does leadership look like in your team?

Supplementary questions included:

- What one thing would you say to the chief executive if you had the opportunity?
- What is good about working here?
- What one thing would improve working here?

Headline themes from the discovery phase were presented to the senior management team and included:

- more visibility from the management team
- more sharing of good practice
- develop different ways of communicating and not rely on emails – more face-to-face conversations
- more positive feedback
- develop compassion in leadership
- gain understanding of others' roles and how they affect each other
- stop talking about changes – do them
- recognition of improvements already made.

LEAD ambassadors facilitated a departmental 'time out' session with presentations on the 'Collective leadership' programme and top 10 leadership behaviours. Design phase questions were explored, including:

- gathering examples of collective leadership
- what working practices would they like to keep – what works well?
- what doesn't work well?
- what would you like to develop?
- what do you need to make that happen?

Results were discussed at senior management meetings facilitated by the LEAD ambassadors and led to:

- LEAD ambassadors facilitating a staff engagement forum to provide support and focus on actions
- an engagement forum to gather ideas and opinions from staff
- structured one-to-one interviews between the senior team and the LEAD ambassadors
- developing senior management team communication skills
- developing effective senior team meetings; this has included meeting terms of reference, exploring roles, taking personal responsibilities and exploring other ways of updating each other
- developing senior team self-awareness and applying the top 10 leadership behaviours, especially being visible and interacting with staff.

This work will continue to evolve with the LEAD ambassadors' support.

What is the learning?

- Ensure work is commissioned and sponsored, and contracts outlining roles, responsibilities and expectations are clear.
- Be flexible in your approaches and respond to whatever the area's needs are.
- Understand that the discovery, design and development phases are not linear but ongoing cycles.
- Continue to develop LEAD ambassadors in skills and numbers and prepare to have a recruitment and induction process.
- Ensure case studies are shared and organisational learning is supported.

Quotes from our LEAD ambassadors

"I'm really enjoying meeting new people, getting immersed in everything about the trust and understanding what it's like from the point of view of other colleagues. I'm passionate about leadership and helping others develop as leaders, so being a LEAD ambassador is really right for me."

"I have been well supported with compassionate leadership within my career. I am committed to learning about this, being a role model and sharing this with the organisation so that support and care underpin our collective success going forward. As LEAD ambassadors we're learning really interesting things about how people feel working here and I'm looking forward to reaching out to people to make the data we're gathering come to life, through focus groups and other conversations."

"Improving patient care and staff wellbeing is what we all want. Good leadership plays a key part in trying to achieve this. Historically, leadership has been for only the few. Times have changed; everyone working for the trust plays a huge role in the care we give our patients and the happiness of all our staff. This project encourages everyone who wants to be involved in leadership and improving a wide range of issues to do so. I hope that by working together to be successful in all our aims, no matter how big or small, we will drive improvement trust-wide."

For further information please contact:
amanda.parker5@nhs.net

Case Study 3

Who

Central Manchester University Hospitals NHS Foundation Trust

Programme name

'What matters to me' – creating a social media movement to provide every patient with a high quality, personalised experience at every contact

"Sometimes in the past I have been made to feel like I am pushy and interfering when I have tried to make sure the things that matter to my son happen. Here I haven't. I've been listened to, treated with respect and I think 'What matters to me' has made the difference. The care in this unit is second to none. Nothing is too much trouble and everybody is so professional."

What was the aim?

In line with our culture programme and in support of the trust's philosophy, we set out to provide every patient with a high quality, personalised experience at every contact.

What did they do?

The trust began an extensive engagement programme with patients, their representatives and staff of all disciplines to consider: 'What does a great patient experience look like?' The Figure below represents the feedback we received.

Figure 1: What does a great patient experience look like?

The overriding message highlighted the complexity of patient experience and the need for staff to see the individual, recognising and responding to the issues that matter to them. Based on this finding, the trust named its patient experience programme 'What matters to me'.

The programme's overarching principle is to treat every patient as an individual, encourage staff to ask patients 'what matters' to them as they use services, to listen and to respond to their needs.

Personal ownership and accountability are central to this work, so extensive staff engagement is fundamental to gaining commitment at every level.

With support from the trust's board, we created a social movement to create energy and momentum and ensure the widest possible reach.

We supported the launch of 'What matters to me' with these activities:

- screensaver and regular articles in the trust's weekly newsletter leading up to the launch, to raise awareness and encourage participation; regular articles reporting progress and celebrating achievements
- distributing a resource pack to all areas before the launch, providing background information and signposting divisions to Staffnet where they could download branding to use in their local activity
- a personal email from the chief executive, chief nurse and medical director to all staff launching the campaign
- a 'tweetathon', where staff and patients completed speech bubbles about what matters to them and tweeted using the hashtag #WMTM
- local speech bubble displays to prompt discussion and spread the underlying principles of 'What matters to me'.

"Since the launch of the 'What matters to me' campaign we have seen an increase in the sharing of good news stories and cross-organisational networking among colleagues," according to a patient engagement and involvement manager. "The campaign has not only created a social movement but a continued momentum to engage with patients and staff in new and exciting ways. Social media is where our patients as well as our colleagues are, and that's where we need to be in helping to drive forward conversations and engagement in order to provide every patient, at every point in their patient journey, a personalised patient experience."

A ward manager commented: "The WMTM campaign has been very powerful for patients and staff in bringing the focus on person-centred care as a key goal. We have used 'What matters to me' to ensure we find out about our patients as individuals as part of therapeutic conversations about memories and loved people and activities. We have then recorded this information to ensure everybody looking after that patient knows a little bit more about their personality and preferences. We believe access to this information can influence communication with patients and shape person-centred care planning tailored to the individual. These informal WMTM conversations can reveal crucial information about patients that they may not have disclosed previously if the majority of their interactions with clinical staff are focused on their medical management. Social media has helped to create energy behind the WMTM idea and helped us to remember that everything we do should be tailored to the patients' needs".

What were the outcomes?

The figure below summarises all the feedback gathered to date.

After the launch there were 2.25 million unique views of the #WMTM tweets, with over 1,060 tweets published. By the end of May 2017 there had been 7.16 million unique views, with 4,179 tweets published.

We have maintained momentum by encouraging staff to make a personal commitment to hold 'What matters to me' conversations with patients.

Regular communication and engagement includes:

- staff in clinical areas developing WMTM wall displays about personalised care, which include examples of patient feedback about what matters
- 'What matters to me' logos and branding
- incorporating 'What matters to me' in other workstreams such as the ward/department accreditation programme, outpatient improvements, PALS and complaints
- 'What matters to me' stands at health and wellbeing events
- undertaking specific 'What matters to me' enquires such as 'What matters to you about spiritual care?' and 'What matters about waiting?', which have informed improvement activity

- 'What matters to me' day, the aim of which was to ask staff to have meaningful conversations with each other and their patients about 'What matters to me'.

The programme is taking significant steps as it becomes embedded into everyday practice, demonstrated by teams developing their own initiatives. For example, the critical care team developed 'What matters to me' documentation as a prompt for it to act on the things that really matter to the individual patient.

What is the learning?

- The board's support and aligning the programme to the organisation's priorities and culture were essential to its launch and introduction.
- Staff engagement, involvement and permission to act have been crucial.
- Collective leadership at all levels has been essential to spreading and sustaining the programme.
- Do not underestimate the time it takes. Social media provided a route for rapid spread and engaging staff and patients, resulting in local ownership and response.

For further information please contact:
Debra.Armstrong2@cmft.nhs.uk

Case Study 4

Who
University Hospitals of Morecambe Bay NHS Foundation Trust

Programme name
Creating better care together

What was the aim?

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMB) was placed in special measures in June 2014 after a Care Quality Commission (CQC) inspection, despite investing in frontline staffing, developing clinical leadership teams and revitalising its board. The turnaround since then has been impressive: an inspection in July 2015 resulted in a rating of 'requires improvement'; the trust came out of special measures in December 2015 and after another CQC inspection in October 2016, it was rated 'good' in February 2017.

This transformation was based on developing an organisational culture of continuous improvement, where staff at all levels were enabled as individuals (and in teams) to improve care and show leadership. The complexity and challenges of healthcare provision locally and regionally meant every individual had a role in developing and shaping services, and in ensuring their patients received consistent high quality services in a sustainable way.

The aim was to create a patient-centred, safety focused and forward-looking organisation, with a leadership built around clinical and stakeholder engagement.

What did they do?

The challenge was to reconnect employees with the trust's core purpose – providing high quality, effective services to patients delivered by compassionate, caring and committed staff, working within a common culture that is patient-centred and safety focused.

One of the first tasks was to develop an organisational culture that valued improvement, innovation, transformation and a positive, patient-centred approach.

The trust encouraged innovative thinking that would lead to clinical and financial stability, while maintaining a balance between 'the need for control' and the 'need for experimentation and innovation'.

Leadership behaviour had to continually reinforce care and quality as UHMB's top priorities. The trust wanted to build strong relationship capability among its leaders so that clinical teams could innovate, improve and raise quality, as well as embrace 'uncertainty' and diversity.

The board engaged with employees across the trust to help shape the organisation's vision and determine its underpinning value statements. The five Ps (patients, people, progress, performance, partnerships) became the foundation and set the standard for organisational culture. We then took them further by developing a behavioural standards framework, written by employees for employees. This aimed to embed the values in everything the trust does, and in every interaction with employees and their colleagues, their patients and visitors/relatives.

We included the behavioural standards framework in recruitment (values-based questioning), appraisal (reflection of performance against the standards) and all leadership development programmes, at every level. Professor Michael West's call for compassionate leadership - " Listen with fascination, show compassion and empathy, take intelligent action" – is at the heart of the trust's culture

Our Listening into Action programme is based on the simple premise of empowering staff to lead on making changes to clinical care. It involves frontline staff proposing projects that will make a difference to patient care; projects must get patients and staff involved. The programme was praised by CQC, which said: "it has led to significant quality improvements for patients".

Early examples included:

- An intensive care unit project led by nurses to tackle the pain caused by nose tubes and pressure sores: Pressure sores can lead to infection, affect a patient's length of stay and incur unnecessary costs. The project almost eliminated the incidence of pressure sores, and has saved tens of thousands of pounds.
- Specific education and training to spot signs of acute kidney infection: Following up an NHS Improvement alert about mortality, an associate specialist doctor set up a Listening into Action project and a training programme that is saving lives.

The drive for continuous quality and safety improvement requires exceptional leadership at every level, and must recognise the impact clinicians can make by leading the quality agenda.

Trusts facing challenges often focus on governance processes and performance management, at the expense of innovation. UHMB recognised these are not mutually exclusive: the two 'leadership systems' must run together. We refer to this as System 1 and System 2 thinking: System 1 is about governance – what is explicit and known. System 2 is what binds things together, drives innovation, experimentation and discretionary effort, and builds both agility and creativity. Both "mind" and "heart" are taken into account.

As System 2 was about connecting with employees at an emotional level, it was important the trust did all it could to ensure they felt valued, supported and engaged.

Evidence suggests organisations that look after their employees are rewarded with greater productivity and improved quality outcomes.

Through the #FlourishatWork Campaign, UHMB encourages every employee to take care of themselves through simple measures to improve their health and wellbeing, such as increasing physical activity, nourishing and hydrating themselves better, or looking after their mental wellbeing. We set a range of health and wellbeing challenges supported by:

- daily walks
- installing watercoolers in every area
- removing sugary drinks and goods from vending machines
- organised sporting activities
- mental wellness giveaways.

In the 12 months since the campaign's launch, it has motivated many to do something different to improve their physical, emotional or mental wellbeing, or all three.

What were the outcomes?

Since the transformation programme began four years ago, outcomes include:

- patient safety improvements
- significantly improved levels of staff engagement
- increased staff recruitment and retention
- numerous examples of how employees have been inspired to improve patient or staff experience.

What is the learning?

The initiative is based on a simple premise: treat your staff well, look after them, nurture them and they will respond in kind, getting involved to make improvements and ensure the highest levels of patient care are maintained.

For further information please contact:
jackie.daniel@mbht.nhs.uk

While this organisation did not use NHS Improvement's culture toolkit, it created its own culture journey to ensure improvements were made, acknowledging the importance to the NHS of developing compassionate and inclusive cultures.

Case Study 5

Who
Northumbria Healthcare NHS Foundation Trust

Programme name
Values-based recruitment

What was the aim?

Our aim using values-based recruitment was to evaluate how closely a candidate's values align with those of our organisation. Our values were developed in 2012 using staff focus groups. They align with NHS Constitution values and are:

- patients first
- safe and high quality care
- responsibility and accountability
- everyone's contribution counts
- respect.

What did they do?

In 2013 we started to embed the trust's values across the employee lifecycle with the starting with the selection interview. Our aim was to develop a values-based interview that could be used for the selection of all new recruits to all roles in the trust and for promotion of existing staff. Depending on level, values-based assessment centres and psychometric assessments are also used.

A structured past behavioural values-based interview was devised by selecting the best questions from a bank of values-based questions whose answers measured person–organisation fit. Candidates were interviewed by panels (that is, more than one hiring manager). Managers were encouraged to add their own role-specific questions, based on the premise that they are better at assessing person–job fit than person–organisation fit (Kristof-Brown 2000). While the same interview structure was used for recruitment to all roles in the trust, several levels of clinical and non-clinical bank questions were devised, ranging from apprentice to managerial.

Values-based interview content was developed from job analysis by core staff groups such as staff nurses, to ascertain 'aligned' and 'non-aligned' behaviours, and behaviours to be expected (and not expected) from effective staff members. Values-based interview questions were written to illicit these behaviours. Managers were given appropriate guidance to ensure objective and standardised processes.

Example question

R7. When have you made a patient / their family / a colleague feel valued?

- *If the candidate gives you a non-specific example say* 'can you give a specific example of when you have done this?'
- How did you know how to approach them?
- Why did you approach them?
- How did you know you'd made them feel valued?
- What did you learn from the experience?

Aligned behaviours					Non-aligned behaviours
	Rate each answer				
	Excellent	Very good	Good	Just acceptable	Unacceptable	
Can provide a relevant example	4	3	2	1	✕	Cannot provide a relevant example
Seeks to understand others' needs	4	3	2	1	✕	Makes assumptions about the person and their needs
Tailors their approach and style to meet the patient / their family / a colleagues needs	4	3	2	1	✕	Focusses on what they need from the relationship, does not adapt their approach
Reflects on the impact of their behaviour	4	3	2	1	✕	Lacks awareness of the impact of their behaviour

Average score across the value:

4	3	2	1	✕
Excellent	Very good	Good	Just acceptable	Unacceptable

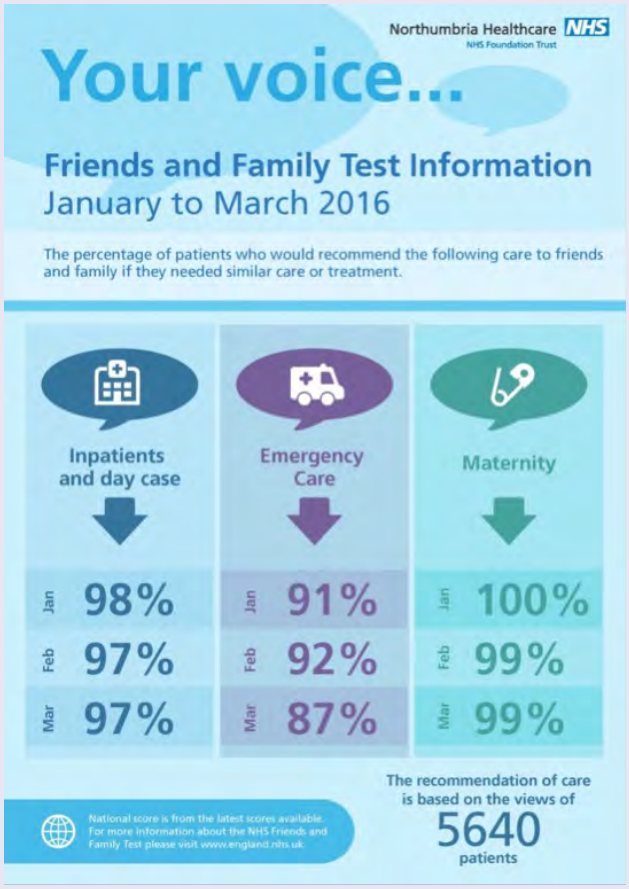
What were the outcomes?

Following a series of pilots, values-based interviewing was rolled out across the organisation. All recruitment materials and processes needed to be changed and 500+ recruiting managers trained in a two-hour interactive skills-based session. A 'trained user' register was created and guidance issued, stating that at least one panel member must be a trained user.

Strategically, our values have also been incorporated in the appraisal process, probationary period, job descriptions and recruitment materials and embedded in the existing staffing groups.

Data suggested that staff experience had improved since the introduction of values- based interviewing. Overall staff engagement in 2015 was rated 4:02 (We evaluated above the national average for acute trusts of 3.8), an increase from 3.77 in 2012 (national average 3.68). The increase in this marker is an important outcome because of the clear links between staff engagement, patient safety and patient mortality rates (West and Dawson 2011). In addition, the Care Quality Commission rated the trust 'outstanding' in 2016, remarking that "staff consistently communicated with patients in a kind and compassionate way" and "staff went above and beyond in the ways they cared for patients".

Patient feedback about staff is perhaps the most revealing evaluation of whether a selection method has been successful in healthcare. Results from the Friends and Family Test in early 2016 suggest patients are very likely to recommend NHCFT to friends and family across three key areas.



Panels' reactions

Of responses 82.5% rated values-based interviewing good or excellent overall and 77.7% agreed or strongly agreed that the interview was fair.

Candidates' reactions

Candidates felt they were informed about the process, were treated well and were comfortable during the values-based interview. Most felt the questions were relevant to the job they had applied for.

What was the learning?

The panels' reactions indicated areas for development were ease of use and including job-specific questions.

With regards to ease of use, the feedback highlighted that the paperwork and in particular the question bank format needed to be simplified and made more user friendly. The need to include job-specific questions should be reiterated to panels.

Questions in the values-based interview bank look at person–organisation fit, not technical, job-specific questions; they need to be revised to ensure we look at person–job fit. Question banks need to be continually refreshed with the help of internal stakeholders to maintain their relevance and to avoid their value from being diminished with repeated use.

For further information please contact:
Joanna.Cook@northumbria-healthcare.nhs.uk

References

Kristof-Brown AL (2000) Perceived applicant fit: distinguishing between recruiters perceptions of person-job and person-organisation fit. Personnel Psychology 53(3): 643–671.

West M, Dawson JF (2011) Employee engagement and NHS performance. King's Fund. Available at: www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

NHS Improvement

- Leader role job design
- Inclusive recruitment
- Regular leadership forecast update
- Goal setting and goal review
- Setting and using team goals
- Providing feedback on behaviour and performance
- 360 degree feedback
- Measuring compassion

Leader role job design

To offer high quality leadership, leader roles need to be designed strategically to build in key elements such as feedback and autonomy, to help leaders perform at their best and to bring out the best in those they lead.

What is it?

Leadership must provide direction, alignment and commitment in health and social care organisations. This means:

- direction – achieving agreement on what the collective is trying to achieve together
- alignment – effectively co-ordinating and integrating aspects of the work, so it fits together and serves the shared direction
- commitment – people and teams making the collective's success – not just their individual success – a personal priority (Drath et al 2008).

For leaders to do this, their roles have to be designed effectively when job specifications are being drawn up, while performance management and appraisal processes need to be aligned accordingly.

Why is this important?

Designing leadership roles so they deliver direction, alignment and commitment requires strategic thinking about what we expect leaders to do (both individually and collectively) to ensure these three outcomes.

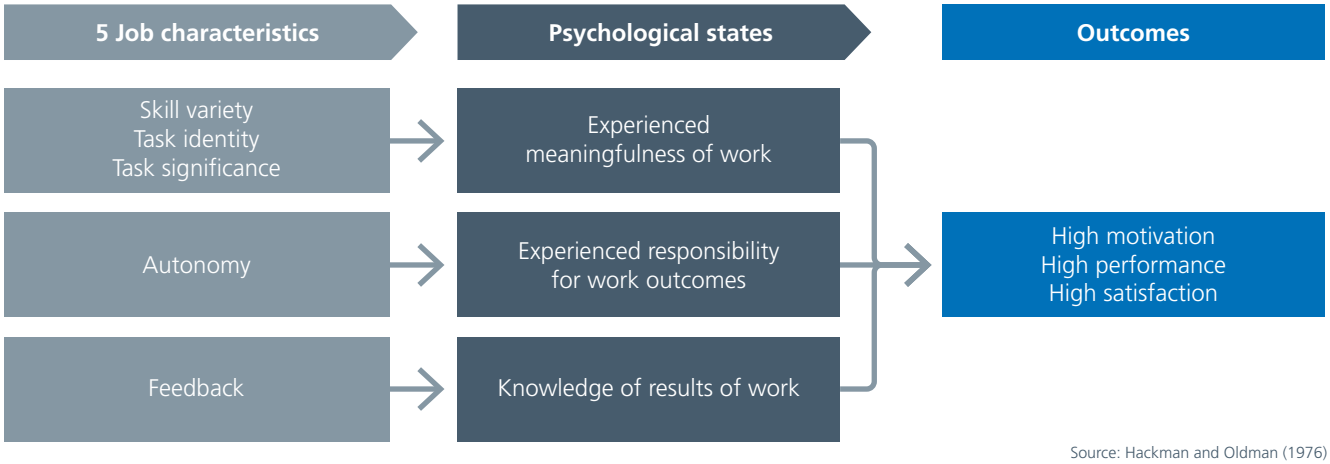
What is the evidence?

One strongly evidence-based approach to designing leadership roles is the Job Characteristics Model (Hackman and Oldham 1976, 1980).

This model identifies features of work that lead to intrinsic motivation, and helps the user build these features into jobs and leadership roles, to make them rewarding and motivating. The purpose is to foster three work-related psychological states, all associated with motivation:

- sense of personal responsibility – providing people with opportunities to feel personally responsible for the outcomes of their work
- meaningfulness – people's sense of purpose about work: a perception that it matters in some way
- knowledge of results – people's ability to determine how they are performing, so they develop a sense of their own effectiveness at work.

Job characteristrics model



Source: Hackman and Oldman (1976)

Building on the model: five core job characteristics

Hackman and Oldham (1980) remains relevant today. They identified five job characteristics that promote the three psychological states described above:

1. skill variety – the extent to which people are expected to draw on a diverse set of job skills and abilities; meaningful work requires people to use their capabilities
2. task identity – the extent to which a job allows people to complete a whole, identifiable piece of work, with an outcome they can perceive
3. task significance – the extent to which the output of work has an impact on others – either inside the organisation or outside, such as service or product users
4. autonomy – freedom to decide how to work and to accomplish goals; autonomy at work is central to developing a sense of personal responsibility
5. feedback – performance feedback is critical for enabling people to gain knowledge of their work's results.

Of these five, the first three create meaningfulness, the fourth fosters responsibility and the fifth facilitates knowledge of results.

Intrinsic motivation will be higher if these characteristics are present in people's jobs and therefore in leadership roles. This means that organisations need to pay attention to job design, structuring jobs and work activities to ensure these five characteristics are present as far as possible.

Testing the model

Humphrey, Nahrgang and Morgeson (2007) tested the model using meta-analysis. The results suggested substantial relationships between job characteristics and outcomes, again supporting the idea that motivation can be improved through leader role job design.

For managers and practitioners, these results show the importance of carefully considering and investing in leader role job design. The returns, in terms of performance, wellbeing and (importantly) motivation, seem to be well established.

Bringing the theory together with a single concept

Pierce et al (2009) developed a single concept of role design: psychological ownership. They suggested that Hackman and Oldham's five core job characteristics give rise to a state of job-related psychological ownership. This comprises a sense of 'mine-ness' about a person's job. It is more than simply 'a' job, rather it is 'my job: I own it and control it, and it matters to me'.

They argue that each job characteristic gives rise to psychological ownership in a different way. So the characteristic 'autonomy' may give employees more opportunities for control over their work. Meanwhile, 'task identity' requires the person to invest themselves personally into the job and establish an intimate relationship with their work. Both characteristics could develop a person's sense of job-related psychological ownership.

How does it work?

Leader role design involves applying Hackman and Oldham's five core job characteristics (variety, task significance, autonomy, task identity and feedback) to the design of leader roles. We explain how to apply each of these below:

Variety

The leader role needs to focus not only on repetitive tasks, but on some tricky challenges and the need to cope with unforeseen obstacles. Most leader roles contain this element automatically, but it is still important to make this clear. Some first-line level leaders do not have great task variety, which might lead to them being bored. Others might have too much variety, and risk losing focus or getting into too much conflict with other parts of the organisation.

Responsibility

For leaders, responsibility and accountability are natural partners. But often, leader roles are not designed to be accountable for their areas of responsibility. Ideally, their responsibilities – in terms of tasks as well as people-related accountabilities – should be clearly identified. This helps leaders see that they are personally responsible for the outcomes (successes and failures alike) that result from their actions.

Leaders need to understand the significance of the leadership they provide to others – not only to their team, but their peers and others in the organisation – so they can work effectively. This is related to bigger-picture thinking and other competencies that leaders are often told to develop. But it is hard to do that if the job is not designed in a way that supports this development.

Autonomy

Autonomy goes hand in hand with responsibility. If responsibilities and accountabilities are clearly agreed on, leaders should be free to regulate and control how they achieve what they are responsible for (within the boundaries of what is acceptable in the organisation and within the law).

This element includes such aspects as decision-making authority, aligned with the leader's scope of responsibility. It also incorporates some leeway in determining how they want to lead and produce direction, alignment and commitment (for example, their leadership style as well as how they implement processes).

It is not easy for leaders to do a good job if others are overly prescriptive about how they must lead. This risks the leader losing motivation as well as authenticity.

Task identity

In general, people are more satisfied if they can work on a task 'as a whole' rather than only in parts. In this respect, leaders are no different. If they can lead a process, project or team that has a distinctive purpose, function or goal, it is easier for them to motivate their team and more satisfying to lead it. It is also easier to measure success.

An example of a lack of task identity is when a leadership role is created for a 'pseudo-team' – a group of people that do not really comprise a team. For example, they may have no interdependence, no joint goals that they are striving to achieve, or no distinctive function or role within the organisation.

Feedback

Everyone benefits from feedback, and this includes leaders. Good design of leader roles ensures a high level of feedback. Leaders need to be recognised for the outcomes their teams produce. But they also need recognition for the outcomes of (and sometimes, the effort they put into) their leadership activities, and what they do to make sure that leadership happens – in terms of direction, alignment and commitment.

Many leaders get measured only on the key performance indicators (KPIs) of their group and not on their leadership actions. This is risky, as it can lead to bad promotions as well as incentivising 'bad' leadership – in other words, leadership focusing on reaching KPIs at all costs.

Tip: The Job Diagnostic Survey is a tool developed by Hackman and Oldham to help managers diagnose their work environment.

References

Drath WH, McCauley CD, Palus CJ, Van Velsor E, O'Connor PM, McGuire JB (2008) Direction, alignment, commitment: toward a more integrative ontology of leadership. *The Leadership Quarterly* 19 (6): 635–653

Fried Y, Ferris GR (1987) The validity of the job characteristics model: a review and metaanalysis. *Personnel Psychology* 40 (2): 287–322

Hackman JR, Oldham GR (1976) Motivation through the design of work: test of a theory. *Organizational Behavior and Human Performance* 16 (2): 250–279

Hackman JR, Oldham GR (1980) *Work redesign*. Harvard, Cambridge, MA

Humphrey SE, Nahrgang JD, Morgeson FP (2007) Integrating motivational, social, and contextual work design features: a meta-analytic summary and theoretical extension of the work design literature. *Journal of Applied Psychology* 92 (5): 1332–1356

Pierce JL, Jussila I, Cummings A (2009) Psychological ownership within the job design context: revision of the job characteristics model. *Journal of Organizational Behavior* 30 (4): 477–496

The Job Diagnostic Survey

Use the scales below to indicate whether each statement is an accurate or inadequate description of your present or most recent job. After completing the instrument, use the scoring key to compute a total score for each of the core job characteristics.

Response scale

1	2	3	4	5
Not at all descriptive	Not very descriptive	Somewhat descriptive	Mostly descriptive	Very descriptive

1	I have almost complete responsibility for deciding how and when the work is to be done.	1	2	3	4	5
2	I have a chance to do a number of different tasks, using a wide variety of different skills and talents.	1	2	3	4	5
3	I do a complete task from start to finish. The results of my efforts are clearly visible and identifiable.	1	2	3	4	5
4	What I do affects the well-being of other people in very important ways.	1	2	3	4	5
5	My manager provides me with constant feedback about how I am doing.	1	2	3	4	5
6	The work itself provides me with information about how well I am doing.	1	2	3	4	5
7	I make insignificant contributions to the final product or service.	1	2	3	4	5
8	I get to use a number of complex skills on this job.	1	2	3	4	5
9	I have very little freedom in deciding how the work is to be done.	1	2	3	4	5
10	Just doing the work provides me with opportunities to figure out how well I am doing.	1	2	3	4	5
11	The job is quite simple and repetitive.	1	2	3	4	5
12	My supervisors or colleagues rarely give me feedback on how well I am doing the job.	1	2	3	4	5
13	What I do is of little consequence to anyone else.	1	2	3	4	5
14	My job involves doing a number of different tasks.	1	2	3	4	5
15	Supervisors let us know how well they think we are doing.	1	2	3	4	5
16	My job is arranged so that I do not have a chance to do an entire piece of work from beginning to end.	1	2	3	4	5
17	My job does not allow me an opportunity to use discretion or participate in decision making.	1	2	3	4	5
18	The demands of my job are highly routine and predictable.	1	2	3	4	5

19	My job provides few clues about whether I'm performing adequately.	1	2	3	4	5
20	My job is not very important to the company's survival.	1	2	3	4	5
21	My job gives me considerable freedom in doing the work.	1	2	3	4	5
22	My job provides me with the chance to finish completely any work I start.	1	2	3	4	5
23	Many people are affected by the job I do.	1	2	3	4	5

Scoring key:

Skill variety (SV) (items #2, 8, 11*, 14, 18*) = _/5 = _

Task identity (TI) (items #3, 7*, 16*, 22) = _/4 = _

Task significance (TS) (items #4, 13*, 20*, 23) = _/4 = _

Autonomy (AU) (items #1, 9*, 17*, 21) = _/4 = _

Feedback (FB) (items #5, 6, 10, 12*, 15, 19*) = ___ /6 = ___

(*Note: For the items with asterisks, subtract the score from 6.)

Total the numbers for each characteristic and divide by the number of items to get an average score.

Now calculate the Motivating Potential Score by using the following formula:

$$\frac{SV + TI + TS}{3} \times AU \times FB$$

MPS scores range from 1 to 125.

Source: J Richard Hackman and Greg R Oldham, Work Redesign © 1980 by Addison-Wesley Publishing Company, Inc. Reprinted by permission of Addison-Wesley Longman, Inc.

Inclusive recruitment

With various groups experiencing discrimination in the workplace – including the NHS – it is important to take a proactive approach to help redress the balance when it comes to recruitment, promotion and performance management.

What is it?

Inclusive recruitment is a working practice designed to right the wrongs that people from various minority groups experience, including discrimination in relation to selection, promotion and performance management.

Examples of inclusive recruitment include:

- setting and quickly achieving ambitious goals for ensuring that staff are demographically representative of the local community they serve, with an aim to achieve this at every level within five years
- setting and quickly achieving ambitious goals for ensuring that minority groups are not discriminated against in relation to selection and promotion (as well as in other areas such as disciplinary action), with an aim to achieve this at every level within one year
- making sure leadership at every level is representative, with an aim to achieve this at every level within five years
- ensuring there is no evidence of discrimination in selection and promotion decisions, with an aim to achieve this at every level within one year
- making sure staff do not experience discrimination, harassment or bullying at work on the basis of their demographic characteristics, with an aim to achieve this at every level within one year.

Why is this important?

People from various minority groups have unfortunately been subjected to discrimination over many years within the NHS. Recent research shows little progress has been made in the past 20 years to address discrimination against black and minority ethnic (BME) staff in the NHS.

Roger Kline's (2014) report, *Snowy white peaks*, draws attention to discrimination on the basis of ethnicity and gender, particularly at more senior levels of NHS organisations. It highlights that despite many calls to address the problem, progress is slow or non-existent.

We know that discrimination profoundly and pervasively damages the health, wellbeing and quality of work life of the many staff affected (Tomlinson and Schwabenland 2010). Research also shows that in NHS organisations where staff are disengaged, demoralised or demotivated (for whatever reason), they will generally provide poorer patient care (Dawson et al 2011).

Women, lesbian, gay, bisexual and transgender (LGBT) staff, people with disabilities and certain religious groups are poorly represented in senior positions, and the national staff survey data reveals that at all levels, these groups experience greater discrimination (West et al 2015).

Where staff experience discrimination as a result of their identity as gay, Muslim disabled or black, it is highly likely that patients from these groups

experience similar discrimination in their interactions with NHS staff (West et al 2015).

The National Improvement and Leadership Development Framework, Developing People – Improving Care (National Improvement and Leadership Development Board 2016), made inclusion a priority for the sector, ensuring appropriate representation at all leadership levels and emphasising the importance of valuing difference and nurturing inclusivity.

Why is this important in the NHS?

The NHS is based on the principle of providing quality care for all, and it is a source of great pride to the people of the United Kingdom. To safeguard its values, the whole system must take responsibility for solving the problem of discrimination. It will take concentration, vigour, courage and persistence to ensure that this change is effected and sustained over time.

The culture of the NHS should be sustained by the core values in the NHS Constitution, including respect and dignity, compassion and inclusion (Department of Health 2015). These values have particular resonance given the diversity of the NHS workforce.

What is the evidence?

There is strong evidence from within the NHS that where staff in patient-facing roles are representative of the communities they serve, trusts perform significantly better in terms of care quality and financial performance (King et al 2011). This is at least partly due to the greater compassion and higher levels of civility that patients experience in these trusts (King et al 2011).

There is also clear evidence, at least partly drawn from NHS data, that where the organisational leadership better represents the ethnicity of staff, there is more trust, stronger perceptions of fairness and overall better staff morale (Avery et al 2008, King et al 2017, Lindsey et al in press).

But the issue is not simply a business case for change: it is a profound moral, social and cultural issue that we must all address collectively, from a values and virtue perspective (van Dijk et al 2012).

Making a difference

The King's Fund was commissioned by NHS England to assess the scale of discrimination in the NHS. Its report – Making the difference – used data from the 2014 NHS Staff Survey, as well as wider work on climates of inclusion, to suggest strategies for lasting and pervasive change. Its key findings and recommendations (West et al 2015) include:

- Overall, levels of reported discrimination in the NHS Staff Survey vary significantly by type of trust, location, gender, age, ethnicity, sexual orientation, religion and disability status
- Reported levels of discrimination are highest in ambulance trusts
- Overall, women are less likely to report experiencing discrimination than men (apart from ambulance trusts)
- Older staff are less likely to report experiencing discrimination than younger staff
- Reported levels of discrimination are highest for black employees and lowest for white employees. All other non-white groups are far more likely to report experiencing discrimination than white employees
- People from all religions report experiencing discrimination on the basis of their faith. Reported discrimination is by far the highest among Muslims
- Staff with disabilities report very high levels of discrimination. Levels of reported discrimination are higher against people with disabilities than any other of the protected characteristics groups
- Organisations can draw on well-evidenced approaches to inclusion to build positive cultures of care to reduce levels of discrimination.

Many individuals, teams, organisations and national bodies in the NHS are working hard to create climates of fairness, inclusion, compassion and equality. Every individual, team, leader, organisation and overseeing body must make comprehensive and sustained efforts to do the same because the evidence is that it does make a difference (Armstrong et al 2010, Kearney and Gebert 2009, Kossek et al 2006).

How does it work?

Effective diversity management and inclusive recruitment policies, practices and procedures play a vital role in shaping and reinforcing equal employment.

Specific approaches include:

- selection and promotion policies that set hard, challenging but realistic goals to promote greater numbers of demographically under-represented leaders; most organisations should set a challenge to achieve representativeness at all levels within five years
- coaching and mentoring members of under-represented groups
- mobility policies and quotas to influence selection and promotion decisions
- job security including, for example, providing additional conditions for employees from protected classes
- appraisal processes, disciplinary procedures and rewards systems that ensure progress towards ambitious goals
- job design that includes workplace accessibility
- methods for encouraging staff participation in decision making, information sharing, dialogue and interaction throughout organisations.

Tip: It is particularly important to have visible and sustained senior management support for positive diversity and inclusion policies and practices. But it is equally important that middle managers and frontline supervisors effectively implement and consistently reinforce them.

Tip: Recruitment packs and advertisements could state the importance of teamwork, tolerance, openness and celebrating individual and collective identities as 'the way things are done around here'.

Organisations can also increase the representation of under-represented groups by scrutinising and adjusting their ways of working:

- Build a reputation for diversity and inclusion – When managers develop diversity recruitment strategies, they need to be clear about how increasing and valuing diversity is a strategic objective for the organisation. Communicating this to potential employees will socialise them to the organisation's cultural norms and diversity values (Gilbert and Ivancevich 2000).
- Use formal recruitment processes – Informal recruitment processes are notorious for attracting 'like for like'. This is because interviewees have a subconscious bias towards people who are similar to them. This effect is amplified if recruitment occurs via personal networks as opposed to formal processes. Opting for open and transparent recruitment helps ensure individuals of diverse sociodemographic backgrounds are given equal chances to apply and interview.
- Use multiple recruitment methods – Using one method for recruitment and/or assessment will filter out those who perform less well on the chosen method. This filtering may not be due to competency but to language difficulties, learning difficulties or stereotype threat, which leads to performance anxiety (Armstrong et al 2010). To mitigate this risk of adverse impact on minority groups in particular, it is best to use a combination of application, psychometric tests and semi-structured interview with multiple raters present to challenge subconscious bias (Coleman 1995).
- Set intelligent quotas – Goal setting is an effective way of making change happen fast. Diversity goal setting should be done intelligently and informed by data.
- Publicise ambitious targets – Diversity targets should be communicated at every level of every NHS organisation. There needs to be open communication about the impact of organisations' action on diversity.

References

Armstrong C, Flood PC, Guthrie JP, Liu W, MacCurtain S, Mkamwa T (2010) The impact of diversity and equality management on firm performance: beyond high performance work systems. *Human Resource Management* 49 (6): 977–998

Avery DR, McKay PF, Wilson DC (2008) What are the odds? How demographic similarity affects the prevalence of perceived employment discrimination. *Journal of Applied Psychology* 93: 235–249

Coleman HL (1995) Strategies for coping with cultural diversity. *The Counseling Psychologist* 23 (4): 722–740

Department of Health (2015). The NHS constitution for England. Department of Health, London. Available at: www.gov.uk/government/collections/nhs-constitution-for-england-resources (accessed 20 July 2017)

Gilbert JA, Ivancevich JM (2000) Valuing diversity: a tale of two organizations. *The Academy of Management Executive* 14 (1): 93–105

Kearney E, Gebert D (2009) Managing diversity and enhancing team outcomes: the promise of transformational leadership. *Journal of Applied Psychology* 94 (1): 77–89

King EB, Dawson JF, West MA, Gilrane VL, Peddie CI, Bastin L (2011) Why organizational and community diversity matter: representativeness and the emergence of incivility and organizational performance. *Academy of Management Journal* 54 (6): 1103–1118

King E, Dawson JF, Jensen J, Jones K (2017) A socioecological approach to relational demography: how relative representation and respectful coworkers affect job attitudes. *Journal of Business and Psychology* 32: 1–19

Kline R (2014) The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Middlesex University Business School, London

Kossek EE, Lobel SA, Brown J (2006) Human resource strategies to manage workforce diversity. In Konrad AM, Prasad P, Pringle J (eds.) Handbook of workplace diversity: 53–74. Sage, London

Lindsey AP, Avery DR, Dawson JF, King EB (2017) Investigating why and for whom management ethnic representativeness influences interpersonal mistreatment in the workplace. *Journal of Applied Psychology*. Epub. DOI: 10.1037/apl0000238.

National Improvement and Leadership Development Board (2016) Developing People – Improving Care. Department of Health, London. Available at: www.improvement.nhs.uk/resources/developing-people-improving-care/ (accessed 20 July 2017)

Tomlinson F, Schwabenland C (2010) Reconciling competing discourses of diversity? The UK non-profit sector between social justice and the business case. *Organization* 17: 101–121

van Dijk H, van Engen M, Paauwe J (2012) Reframing the business case for diversity: a values and virtues perspective. *Journal of Business Ethics* 111: 73–84

West M, Dawson J, Kaur M (2015) Making the difference: diversity and inclusion in the NHS. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs (accessed 19 July 2017)

Regular leadership forecast update

An annual update of your leadership forecast ensures that your organisation's changing needs inform your leadership strategy and talent management programmes.

What is it?

This method involves annually updating the leadership workforce analysis (Phase 1 toolkit). The leadership workforce analysis helps you collect information necessary to evolve the leadership strategy and resulting talent management priorities.

This tool:

- focuses on the likely future state of 'key roles' and hard-to-fill roles – which are essential to support high quality care cultures and ensure your organisation's strategy is delivered over the next five-to-ten years; it works out the gaps in relation to key roles to support the design of your leadership strategy
- covers high-level likely future states of your workforce as a whole, because everyone modelling the values and taking responsibility (compassionate and collective leadership) is essential for high quality care; it does not look at these areas in detail, as they would form part of your organisation's broader workforce plan and workforce development plan
- gathers information on the future organisational design because this will influence how the organisation is structured and how the different parts work together to deliver high quality and compassionate care; in time, the leadership forecast update and organisational design processes can be integrated, which will help ensure that structures, organisational processes and leadership are symbiotically integrated to ensure coherence.

The update is far less involved than the initial analysis.

Why is it important?

In a rapidly changing environment, it is important to forecast your leadership workforce needs, and to regularly revise them. If your organisation is to deliver continuously improving, safe, high quality compassionate care and meet its business strategy objectives over the next five to 10 years, it will need leaders with the right skills in key roles. So the analysis needs to be intelligently revised, based on a reading of evolving strategies in a changing environment – for example, the development of sustainability and transformation partnerships (STPs).

Because those in key roles have a major influence on the organisation's culture, this tool helps you undertake a talent review and gap analysis to support compassionate and collective leadership. This helps you to ensure you have leaders in post substantively, rather than vacancies or interim position holders, and enough individuals in the leadership pipeline – with the skills, motivation and appropriate values and behaviours – to be ready when there are vacancies or to step into new leadership roles.

What is the evidence?

Leadership forecast updates play a central role in ensuring that the overall leadership strategy is relevant, adaptable, and specifies the collective capabilities of formal leaders and all staff members needed for compassionate and collective leadership.

The approach draws on the extensive work of the Center for Creative Leadership (McGuire and Rhodes 2009, Hughes et al 2013) in working with organisations in healthcare and other industries to develop and implement leadership strategies.

How does it work?

The tool presents four sets of questions that are answered by collecting data and consulting key people across your organisation.

> **Tip:** Set up a small team of three to five people who know the organisation, understand its wider environment and are familiar with the processes for acquiring, retaining and developing leadership talent. They can help you conduct the interviews and answer the questions.

Step 1: Re-familiarise yourself with your strategic drivers and identify any changes that are likely

In preparing the initial leadership workforce analysis, you will have considered and discussed with your board the strategic drivers from the organisation's strategy and the implications for the leadership strategy as a whole. Now you need to revisit the strategy to identify any major changes since you conducted that analysis.

This information is important, as it supports the work of the steps below. For example, in Step 2 it helps assess the demand for key future roles aligned to the strategic intent and related skills.

You also need to identify any changes in the environment with implications for future leadership requirements. This environmental scanning should include:

- changes or projected changes in demand for services
- changes in organisations within the healthcare system and supporting organisations (for example, in mergers, social care or the voluntary sector)
- competition that may affect demand and supply of services
- regulators' and inspectors' actions and policies
- government policies
- chance events and changes (such as a new virus identified or a new treatment)
- technology changes that may affect requirements (major new treatment methods or drugs).

Consider how each of these may change future requirements for leadership in relation to key roles or hard-to-fill roles and the qualities, skills and behaviours needed.

Step 2: Identify the current state for key roles

Now identify the key roles for your organisation in the future. One way of doing this is to review your organisational structure chart, using criteria before you have any discussions. This may help reduce any natural bias.

Suggested criteria include:

- Strategic impact – Losing a qualified post holder for even a modest amount of time would affect the organisation's success in terms of quality of care, patient confidence, business continuity or otherwise achieving the business strategy
- Immediacy – The short-term loss of the post holder would seriously affect service delivery, patients or service users, quality of

care, financial efficiency, operations, work processes, staff morale or the reputation of your organisation

- Demand – The job market for post holders will be tight because of internal or external factors
- Regulations – There is a projected regulatory requirement for the post
- Uniqueness – The position requires competencies that will be unique to the organisation or the particular market in which your organisation will be operating – for example, if you are specialist healthcare provider.

You can then use conversations and/or HR data to provide more information on projected needs in relation to quantities, skills and behaviours and qualities. You will need to consult people with care and sensitivity because identifying certain positions as key roles in the future may suggest that other positions will be less important, leaving staff feeling anxious or disempowered.

These questions will help you develop a clearer picture of your needs:

Quantities

- What are likely to be the key roles for our organisation in the future?
- What are the current key roles and are they filled?
- What is the demographic and diversity make-up of staff (extracted from a workforce plan)?
- What is the current demographic and diversity make-up of key roles?
- What should the demographic and diversity make-up of key roles be in future?

Skills and behaviours

- What will be the skills and knowledge required of key roles in future?
- What is the current position on the skills and knowledge required of key roles?

Qualities

Possible data or information sources to inform discussions on skills and behaviours, include:

- outputs of assessment centres
- leadership style assessment or personality profiles
- HRIS data, outputs of talent management forums or review sessions
- career profiles
- ability testing
- staff surveys
- observations
- culture surveys
- interviews.

Step 3: Work out the gaps and priorities for key roles

Having conducted steps 1 and 2, you can use the information to identify any gaps.

Step 4: Amend the existing leadership workforce analysis accordingly

Determine policies and procedures arising from the revisions, consulting widely with key individuals and departments, including HR, OD, the executive team, non-executive members and patient representatives.

Tips

- Make sure you don't generate so much data in this exercise that it becomes overwhelming. The hard work has already been done on the leadership workforce analysis, so this is simply an intelligent updating exercise
- It will be vital that you draw on a range of knowledgeable informants across the organisation, to ensure a reasonable degree of accuracy
- This analysis is more an art than a science. However, the more care that goes into the process, the more accurate the analysis will be and ultimately the more helpful in enabling the organisation to anticipate leadership needs.

References

Hughes RL, Beatty KM, Dinwoodie D (201¬3) Becoming a strategic leader: your role in your organization's enduring success. Jossey-Bass, San Francisco, CA

McGuire JB, Rhodes GB (2009), Transforming your leadership culture, John Wiley and Sons, San Francisco, CA

Further reading

Van Velsor E, McCauley CD, Ruderman MN (eds) (2010) The Center for Creative Leadership handbook of leadership development (122). John Wiley & Sons, San Francisco, CA

Goal setting and goal reviews

Goals help people stay motivated, perform well and be innovative. But for effective performance management, goals must be challenging, specific and agreed.

What is it?

When teams and individuals have clear objectives or goals at work, they are motivated to work harder and to develop new and improved ways of working. This has been a well-established fact for 60 years.

Everyone working in an organisation needs clear objectives, ultimately derived from the organisation's vision, mission and strategy. The board should have its own five or six clear team objectives. (Many do not.) So should each directorate and department, every team in the organisation and, ideally, every individual.

These goals should be aligned across the organisation so that everyone's efforts are collectively focused on achieving the same outcomes:

- high quality, safe, compassionate care
- high quality patient experience
- efficiency and innovation.

Why is it important?

In the best-performing healthcare organisations, all leaders, from the board to the front line, make it clear that high quality compassionate care is the organisation's core purpose and priority (Dixon-Woods et al 2013). Targets, productivity, cost cutting, efficiency and regulatory requirements are obviously important, but in the best-performing organisations high quality care is the top priority.

While cost-effectiveness is vital, given the demands on health services, case studies suggest that leaders must be vigilant in ensuring this focus never appears to staff to trump a concern with delivering high quality, safe, compassionate care.

So a key cultural component for high quality care cultures is clear goals or objectives at every level. Staff in the English NHS report often feeling overwhelmed by tasks and unclear about their priorities, resulting in stress, inefficiency and poor quality care (Dixon-Woods et al 2013). Creating cultures focused on high quality care requires clear, aligned and challenging objectives at every level of the organisation that prioritise this standard of care (West 2013). This is not the same as the target-driven culture of some governments and organisations to drive change in the system – without great success, the evidence suggests (Ham 2014).

Setting these clear objectives begins with the senior management team having a clear purpose and five or six clear objectives (Wageman et al 2008). This clarity of objectives must then be replicated at every level so that each directorate, department, team and individual (via their appraisal process) has clear objectives aligned with the organisation's purposes, vision, mission and values.

Dawson et al (2011) found that where staff reported this type of goal in place, patients reported better care. Patient satisfaction was higher in organisations where staff indicated there were clear goals at every level, and they described experiencing good communication and high levels of involvement in their care decisions.

It is equally important that healthcare organisations establish measures to assess progress towards

achieving these goals so this information can be fed back to staff, enabling them to adjust and improve their performance. However, while this emphasis is helpful in an enabling culture, where there is a strong blaming or punitive approach to employee management, clear objectives can become threatening targets.

What is the evidence?

Goal setting is a core part of performance management and is one area of theory that is particularly well supported by research evidence (Locke and Latham 2013). Locke and Latham summarise these key findings:

- Goal setting results in markedly higher performance than no goal setting (Locke and Latham 1990). More difficult goals also result in higher levels of effort and performance. In performance management, there is a clear imperative to balance goal setting with the development of abilities and competencies.
- Specific goals are better than 'do your best' goals. Goal setting results in higher performance, if goals are specific and measurable (in other words, if the performance standards expected are clearly spelled out and can be measured). Locke and Latham conclude that when people are merely told to do their best, they do not. Goals are not necessarily results-based or outcome-based. Rather goals might blend aspects of results or outcomes with goals that refer to changes in behaviours or specific areas of job performance.
- Goals need to be challenging. Research shows that there is a linear relationship between how challenging a person's goals are and their subsequent performance, except when the goals are clearly unattainable. The SMART acronym (specific, measurable, achievable, realistic, timely) is useful. However, it misses out this critical element of 'challenge'. This may be because it can be uncomfortable to agree challenging objectives (Locke and Latham 2013).

Goals affect performance through four mechanisms:

- Directing behaviour – Goals direct behaviour towards goal-relevant activities and away from irrelevant activities.
- Energising behaviour – Goals lead people to expend greater effort on goal-relevant activities, with harder goals being associated with increased effort
- Boosting persistence – Harder goals tend to promote people who prolong their efforts to achieve those goals. However, prolonged high-intensity effort cannot be maintained indefinitely. Tight deadlines tend to result in a faster work pace for a short period of time.
- Developing one's approach – Goals encourage people to develop achievement and performance strategies. This results in their learning job-relevant skills.

The relationship between goals and performance is moderated by several factors. This means that the extent to which goals result in performance depends on:

- Goal commitment – The relationship between goals and performance is strongest when people are committed to their goals. There are two major predictors of goal commitment: perceived importance of goals and self-efficacy – the extent to which a person feels able to achieve their goals.
- Feedback – People perform better when they receive feedback about how they are performing in relation to their goals.
- Task complexity – Goals relate to performance most strongly for tasks that are low in complexity.

Tip: One way of promoting the importance of goals is to encourage people to take part in setting their own goals as they are likely to view this as fairer than having goals imposed. Other ways include associating a valued incentive with the goal (such as monetary reward), or communicating the goals in an inspirational way.

The two types of goal

An emerging area of research related to task complexity is the difference between performance and learning goals.

- Performance goals are simply goals that involve achieving some level of performance. They are typically simpler than learning goals
- Learning goals involve gaining knowledge or skills, such as new competencies or approaches to work.

The two learning approaches to goals

There is also a theory that people have a preferred style of working, which reflects how they interpret and understand their own goals.

Goal orientation theory describes two learning approaches (DeShon and Gillespie 2005):

- Learning goal orientation – People with this orientation are motivated to learn and understand
- Performance goal orientation – People in this category are motivated to achieve their desired standard, but no more.

Left to their own devices, people tend to work in their preferred style, but a study by Seijts and Latham (2001) suggested that goal orientation effects could be overcome by setting goals in the right way.

Regardless of preferred style, setting challenging learning goals resulted in similar performances from those in both categories. The implication for performance management is that for complex tasks, goal setting should include learning goals as well as performance goals (Woods and West 2014).

How does it work?

As we have seen, there are some clear rules for effective goal setting:

- Goals must be limited in number up to a maximum of five or six
- Specific objectives are far more motivating and helpful than vague requests to 'do your best
- The goals must be challenging.

Tips

- Don't expect people to achieve all their objectives, and certainly don't censure them for not achieving them, or they will simply resist setting challenging objectives next time round. Celebrate and recognise progress towards goal achievement rather than simply attainment. That requires a change in leadership mindsets
- Establish measures to assess progress towards achievement of goals so that you can feed back this information to staff. If we want people to learn, adjust their efforts, identify and overcome obstacles in their work and improve performance, we have to give them ongoing performance feedback. Leaders need to support staff to achieve their objectives, by removing obstacles and building skills
- Every team in every NHS organisation should have this as one of its five or six objectives: 'improving the effectiveness with which the team is working with other teams to deliver care' (or whatever the task focus is). This is because in the NHS, inter-team working is as important to success as intra-team working

- Having clear objectives redirects efforts from irrelevant activities towards a realistic number of strategically important objectives across the entire organisation. It also:
  - activates relevant knowledge and skills among staff
  - leads to increased effort and persistence
  - increases staff interest in their work
  - promotes success (and therefore satisfaction).
- Objective setting can improve not just the 'what' but the 'how' of delivering care. Staff want to deliver the same standard of care that patients need: caring, compassionate, safe and high quality. To make sure that happens, we need to build that in to objective setting and staff development across the NHS.

References

Dawson JF, West MA, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 19 July 2017)

DeShon RP, Gillespie JZ (2005) A motivated action theory account of goal orientation. *Journal of Applied Psychology* 90 (6): 1096

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2013) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23 (2): 106–115

Ham C (2014) Reforming the NHS from within: beyond hierarchy inspection and markets. The King's Fund, London Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf

Locke EA, Latham GP (2013) New developments in goal setting and task performance. Routledge, London

Seijts GH, Latham GP (2001) The effect of distal learning, outcome, and proximal goals on a moderately complex task. *Journal of Organizational Behavior* 22 (3): 291–307

Wageman R, Nunes DA, Burruss JA, Hackman JR (2008) Senior leadership teams: what it takes to make them great. Harvard Business School Press, Boston MA

West MA (2013) Creating a culture of high-quality care in health services. Global *Economics and Management Review* 18 (2): 40–44

Woods S, West MA (2014) The psychology of work and organizations. (2nd edition). Sage, London

Setting and using team goals

Setting clear goals for the team as a whole is essential if team members are to work collectively and effectively towards a common aim.

What is it?

Teams are created to perform a task that individuals working alone or in parallel could not complete, or could only complete with great difficulty. So the task defines the team, rather than the reverse. Once the task is identified, the team can then define its goals. These are the key priorities for the team's work, which all team members commit to work towards collectively.

We need to create teams when a task can best be undertaken by teams rather than simply because people are working in the same location. So the starting point is defining the task (see the box below).

Characteristics of appropriate team tasks

- They are complete tasks rather than a narrow component
- The task creates varied demands that require interdependent working by people with differing skills
- The task requires innovation and quality improvement
- Team members are enabled to grow and develop through working on the task
- Team members have a high degree of autonomy, with the freedom to decide how best to carry out the task (within sensible limits).

The more of these characteristics a task exhibits, the more appropriate it is for a team (West 2012). Then these tasks, and associated mission statements, must be translated into clear goals.

Why is this important?

Clarity of team goals is the single most important predictor of success in healthcare teams (Lyubovnikova and West 2013, West and Markiewicz 2016). However, many teams still do not have clear goals. In some cases, team members may disagree about what those goals are. In others, the goals may be stated in such an imprecise way that they are little more than feel-good statements, with no practical value being added to the team's challenge to reach its goal.

Goal-setting theory asserts that goals should be clear and challenging, and that ideally, team members should be involved in setting the goals (Locke and Latham 2013).

What is the evidence?

The most consistent predictor of team performance across many studies is the clarity of healthcare teams' goals (West and Anderson 1996, Goñi 1999, Poulton and West 1999, Borrill et al 2000, Cashman et al 2004, Dixon-Woods et al 2013). Yet few healthcare teams in our experience take the time to set clear goals.

Team goals (and individual goals) need to be:

- clear and specific – everyone in the team has to understand the goals and understand them to mean the same thing

- challenging – goals that are too easy to achieve are not motivating; goals that are challenging but achievable are
- agreed – goals should be negotiated and agreed by the individual or the team rather than imposed from outside or by the team leader since motivation will then be higher
- measurable – the team needs reliable measures to give it regular and timely feedback on its performance; it should be possible to check how far the team has been successful in achieving its goals, using data.

One of the goals should focus on improving working across teams. This is because teams must work effectively with the other teams and departments within and beyond their organisations, to deliver goods and services effectively.

Goals should also be time-based – usually teams set goals for the year ahead and their performance is evaluated on the basis of whether they have achieved their goals in that timescale. However, even for a shift or surgical team, it is important to have clear goals for the relevant timespan of their work.

Healthcare teams that have these goals in place, and which seek feedback on their performance, deliver safer and higher quality health care than other health care teams (West and Anderson 1996, Goñi 1999, Poulton and West 1999, Borrill et al 2000, Cashman et al 2004, Dixon-Woods et al 2013).

How does it work?

Vision and mission statements

A team will need these two statements.

A vision statement outlines what a team wants to be, or how it wants it to impact upon the world in which it operates. It focuses on the future and provides inspiration.

Examples:

To be the safest A&E team in the country

To be a model of good practice for all the primary healthcare teams in the city

A mission statement articulates the fundamental purpose of the team. It identifies who the customers are and the key processes involved in the team's work. It also specifies the desired level of team performance.

Example:

We will deliver healthcare based on the community's needs, patients' and their carers' preferences, and a commitment to health promotion that ensures we have a positive impact on the community's overall health.

Team goals are aligned with the vision and mission and need to be limited to between five and seven goals, however senior their members. This is for two reasons. First, people have difficulty holding more than seven items in their heads, due to limitations of short-term memory. Also, larger numbers of goals indicate a failure to prioritise critical tasks for success. This reduces effectiveness.

In the NHS, most team goals should include:

- providing high quality and compassionate care
- continually improving that care

- ensuring other team members' wellbeing, growth and development
- ensuring that working relationships and practices with other teams in the organisation are of high quality and continually improving.

Examples:

We will reduce smoking among our practice population by 5% by the end of the present financial year.

We will establish strong and co-operative links with the CCG and improve them year on year.

Tips: features of effective goals

- Make sure there are no more than six or seven goals.
- Goals should be clear.
- Goals should be challenging.
- Goals should be measurable.
- Goals should be shared and understood by all team members.
- Involve team members in setting the goals as this massively increases commitment.

Example: Sample team vision, mission and goals

Anytown Primary Healthcare Team

Vision

We will improve the quality of life for those we serve by ensuring their health care is leading-edge and humane.

Mission

Our mission is to promote the health, growth and wellbeing of all of those in our community, including patients, relatives, community members and practice members, by respecting the individual, encouraging co-operation and collaboration and emphasising excellence in all we do.

Team goals:

- To put as much resource (people, time, money) into health promotion as into illness treatment – measured by resource allocation
- To involve all team members in setting goals and improve our functioning of a team continuously – measured by improvements in team functioning
- To promote the control and quality of life of those with long-term conditions (such as diabetes and asthma) – measured by their ratings of care quality and symptom control
- To improve health outcomes in the Springwood community by seeing decreases in heart disease, cancer, obesity and drug and alcohol misuse
- To improving the quality of relationships we have with other organisations and teams we work with (hospital, other primary health care teams, social services) – measured by their annual ratings of our co-operativeness.

Analysis

The team based its vision on its organisation's wider purpose, which was to provide high quality and safe care for all in the community. It also based its vision on team members' values:

- respecting, valuing and supporting all the people we serve
- co-operation between professions to provide best quality care
- freedom of choice for all individuals
- the importance of equal access to treatment for all
- valuing health promotion and illness treatment equally.

The team then defined its goals as a result of articulating its vision statement. So the goals were derived directly from the team's vision and from its mission statement. They describe clearly team members' overall aims for the work of the practice.

References

Borrill C, West MA, Shapiro D, Rees A (2000) Team working and effectiveness in the NHS. *British Journal of Health Care Management* 6: 364–371

Cashman S, Reidy P, Cody K, Lemay C (2004) Developing and measuring progress toward collaborative, integrated, interdisciplinary health care teams. *Journal of Interprofessional Care* 18 (2): 183–196

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2013) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23 (2): 106–15

Goñi S (1999) An analysis of the effectiveness of Spanish primary health care teams. *Health Policy* 48 (2): 107–117

Locke EA, Latham GP (2013). New developments in goal setting and task performance. Routledge, London

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas E, Tannembaum SI, Cohen D, Latham G (eds.) Developing and enhancing teamwork in organizations. Jossey Bass, San Francisco: 331–372

Poulton BC, West MA (1999) The determinants of effectiveness in primary health care teams. *Journal of Interprofessional Care* 13 (1): 7–18

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds.) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA (2012) Effective teamwork: practical lessons from organizational research. (3rd edn), Blackwell Publishing, Oxford

West MA, Anderson N (1996). Innovation in top management teams. *Journal of Applied Psychology* 81 (6): 680–693

Providing feedback on behaviour and performance

Feedback plays a crucial role in shaping staff performance, but if it is not done effectively it can cause more harm than good.

What is it?

Performance feedback has been defined in different ways, including:

- information given to people and teams about the quantity or quality of their past performance
- information given to people and teams about their success or otherwise, following performance of a specific task
- information that tells people and teams what, and how well, they are doing generally
- information about performance that allows an individual or team to adjust their performance.

Feedback should provide helpful, accurate and timely information that enables individuals or teams to assess their progress towards their objectives and adjust performance accordingly.

Why is it important?

It is fundamental to performance management to give people and teams feedback about their performance because it enables them to adjust their performance to ensure progress towards their desired objectives.

Most managers are aware of the need to provide feedback to employees, but many NHS staff say the quality of the feedback they receive is poor. Feedback should clearly communicate progress against objectives. But more importantly, it should serve a developmental purpose.

Effective feedback helps employees and teams by:

- highlighting what they are doing right, helping to build confidence
- clarifying progress towards objectives
- identifying areas for improvement
- helping to build competence, so they can do their jobs more effectively
- promoting engagement and involvement with the organisation, developing their sense of being valued by it.

What's the evidence?

Feedback to employees needs to be a balance of constructive and developmental information. Most feedback should focus on the constructive because this helps people feel positive, confident and motivated. However, developmental feedback (which reveals gaps between desired and actual performance) is important to performance management too. Without it, employees have no information about how to improve (Ilgen and Davis 2000).

The research produces some useful insights into which form of feedback (constructive or developmental) is most effective at changing behaviour.

In a survey of more than 2,000 UK managers, Nicholson and West found that most criticised their managers for not giving them positive feedback about their work (Nicholson and West 1988). However, when they were asked to analyse their own time use, they put giving positive feedback to their own team members almost at the bottom of their own lists of activities.

Giving feedback poorly can be less effective than giving no feedback at all. Indeed, there is robust evidence that feedback can either enhance or diminish performance (Kluger and DeNisi 1996).

Feedback leads to performance improvement when it informs a person of a necessary change in behaviour, or when it challenges assumptions about the best way to do something at work. This is because feedback given in this way leads a person to pay attention to the task at hand and to the way they are completing it. On the other hand, feedback that is personal (for example, comparing the employee with other team members) promotes a focus on improving or defending oneself, focusing attention away from the task at hand.

Kinicki et al (2004) tested a simple model of feedback and performance improvement and revealed some important practical insights. For example:

- A fundamental judgement that employees make about feedback is its accuracy. The perceived accuracy of feedback depends on the credibility of the communicator and the presence of a 'feedback-rich environment', where feedback is specific, frequent and positive (Baker et al 2013)
- Perceived accuracy is related to a desire to respond to the feedback, although the credibility of the person providing the feedback also has a direct effect on desire to respond
- People tend to perceive positive feedback as more accurate than negative feedback (see Brett and Atwater 2001). But embedding negative feedback in a feedback-rich environment can enhance the extent to which people see it as accurate.

How does it work?

This section identifies the key core principles in providing effective feedback.

Principle 1: Effective feedback is specific and focuses on the person's behaviour and its consequences

For example, a team leader might say: 'I noticed that you stopped the group from agreeing to include those questions in the survey because you felt they were not appropriate. This was in the face of some frustration from other team members. However, this resulted in a much better set of questions that will provide us with more useful information.'

In this instance, feedback focuses on a particular example of behaviour and its positive consequences.

Principle 2: Feedback is most effective in changing and strengthening behaviour when it follows immediately after the behaviour

In some organisations, feedback is often withheld until the annual appraisal meeting. This has very limited impact on behaviour. The team leader (and indeed, all team members) should provide feedback for team members continuously.

Principle 3: Positive feedback is much more effective in changing behaviour than negative feedback

It is important to ensure a strong balance of positive against negative feedback (around 95% positive to 5% negative).

However, the balance is more usually in favour of negative feedback. This is because we are quicker to recognise the discrepancies between actual and desired behaviour in the workplace. So team leaders need to be alert to spot examples of consistency (when expectations and reality match) as often as possible, and then to highlight them frequently (West 2012, Woods and West 2014).

Characteristics of effective feedback

- Timely – delivered close to the event or performance episode
- Frequent –provided regularly and continuously
- Specific –highlighting specific behaviours or aspects of performance
- Verifiable – focused on accurate, verifiable evidence, rather than rumour or inference
- Consistent – consistent in tone and not subject to huge variation
- Private – presented at an appropriate time and place, to avoid embarrassment
- Contextual – communicating consequences and potential outcomes of behaviour, for context
- Description first, evaluation second – providing clear descriptions of performance behaviours before evaluating them
- Viewing performance as continuous – focused on how to demonstrate more good behaviour and less ineffective behaviour to communicate that performance is not simply 'good' or 'bad'
- Identifying patterns – focused more on patterns of poor performance behaviours rather than isolated mistakes
- Demonstrating confidence – communicating the manager's confidence in the employee and emphasising that negative feedback is targeted at the behaviour, not the person
- Collaborative – not only offering ways of improving performance (advice), but inviting ideas from the employee (idea generation)

References

Baker A, Perreault D, Reid A, Blanchard CM (2013) Feedback and organizations: feedback is good, feedback-friendly culture is better. *Canadian Psychology/Psychologie Canadienne* 54 (4): 260–268

Brett JF, Atwater LE (2001) 360° feedback: accuracy, reactions, and perceptions of usefulness. *Journal of Applied Psychology* 86 (5): 930–942

Ilgen D R, & Davis C A (2000). Bearing bad news: Reactions to negative performance feedback. *Applied Psychology: An International Review* 49 (3): 550–565

Kinicki AJ, Prussia GE, Wu BJ, McKee-Ryan FM (2004). A covariance structure analysis of employees' response to performance feedback. *Journal of Applied Psychology* 89 (6): 1057–1069

Kluger AN, DeNisi A (1996) The effects of feedback interventions on performance: a historical review, a meta-analysis, and a preliminary feedback intervention theory. 119 (2): 254–284

Nicholson N, West M (1988). *Managerial job change: men and women in transition*. Cambridge University Press, Cambridge

West MA (2012). Effective teamwork: practical lessons from organizational research (3rd edn). Blackwell, Oxford

Woods S, West MA (2014). The psychology of work and organizations (2nd edn). Sage, London

360 degree feedback

360 degree feedback, also known as multi-rater feedback, refers to the 360 degrees in a circle. This is because it involves individuals seeking feedback from a wide range of colleagues, at all levels, with whom they come into contact in their working lives.

What is it?

The approach is designed to help leaders identify their leadership strengths and development needs. The leader shares a standardised questionnaire with multiple colleagues to invite ratings of their behaviour and performance. The results are then gathered to provide aggregated or individual ratings.

The aim is to prompt anonymous and confidential feedback from multiple sources. Together, these provide a leader with collective insight and self-awareness about how others perceive them in their role.

This feedback comes from subordinates, peers, supervisors and 'others' – people who hold valuable perspectives but may not fit into these categories. Typically, their feedback is gathered through an online questionnaire that they are invited to complete.

Why is it important?

In general, leaders do not accurately gauge how effectively they perform their leadership roles. Many dramatically over or under-rate themselves when compared to ratings from colleagues (Alimo-Metcalfe 1998). Leaders whose self-perceptions match their staff's perceptions are rated as demonstrating higher levels of leadership effectiveness (Bass and Avolio 1994). This suggests that leader self-awareness is crucial for effectiveness.

What is the evidence?

When it comes to the effectiveness of 360 degree feedback, studies have produced mixed results (Seifert et al 2003). Some suggest positive effects, while others suggest no effects at all. In a review of 131 studies (not confined to leadership), Kluger and DeNisi (1996) found only a weak positive effect of 360 degree feedback on performance. Indeed, in one-third of studies the relationship was negative.

In addition, it is hard to establish the effects of 360 degree feedback on leadership effectiveness in isolation, as most studies implement such interventions in the context of training, development or coaching. For example, Thach (2002) accompanied the intervention with coaching, Rosti and Shipper (1998) studied the effects of management training informed by 360 degree feedback and Maurer et al (2002) evaluated the use of 360 degree on employee attitudes in a feedback session.

This approach may be useful when used with training or other interventions, but there is no clear evidence for this. However, Fletcher points out that the scepticism among researchers often arises because 360 degree feedback is sometimes poorly operationalised, and because the information collected is not always used effectively (Fletcher 2001).

The Center for Creative Leadership (Van Velsor et al 2010) highlights three important leadership lessons from its research that support using 360 degree feedback for development in the NHS:

- Leadership is about learning and growing. Leaders are developed, not made. So any 360 degree feedback initiative should be designed to help leaders build on strengths and address their development needs.
- Leadership is about raising self-awareness and using that awareness to make better decisions. Awareness of their strengths and development needs will help leaders understand where to focus their energy for improvement and where they might have much to offer.
- Leadership development is an ongoing learning process and 360 degree feedback can help support that learning process. Having regular feedback, irrespective of age or seniority, is critical to building a strong cadre of leaders in your organisation.

Organisations value 360 degree feedback because it seems more comprehensive than feedback from a single source and more thoroughly assesses performance across a range of different contexts. For example, performance ratings by a supervisor may be based on limited evidence of employee competence because they may not observe the individual in interactions with peers or subordinates.

How does it work?

Fletcher identifies these elements of 360 degree feedback (Fletcher 2008):

- Rating instruments – 360 degree feedback surveys are used to collect ratings of performance. As with other performance measures, raters use rating scales to indicate the effectiveness of particular performance behaviours.
- Raters – Self-ratings of performance are usually used, and the individual is often asked to nominate the people who will assess them. It is important that raters are offered anonymity, as subordinates may feel uncomfortable about rating their boss, knowing they will see their feedback.
- Feedback process – A central administrator, or the person giving feedback to the employee, collects data. Ratings are typically collated so that an average score is provided for each rating alongside a breakdown of the scores from each rating source. It is important to report the average score, but the dispersion of scores across rating sources is often more informative.

How to apply the learning

As with other performance management mechanisms, the science tells us that simply using 360 degree feedback is not enough for performance improvement. What matters is the way the technique is applied in a specific context.

The likelihood that the data gathered through 360 degree will change a person's behaviours depends on:

- the person's feedback orientation (how receptive they are to feedback)
- the organisation's feedback culture (how the organisation goes about giving, interpreting and using feedback).

The person's feedback orientation may make them more or less likely to engage with the feedback process. People with low levels of confidence (low levels of feedback orientation) often avoid receiving formal feedback, in case it unearths others' perception of them as a 'failure'. On the other hand, people with high levels of feedback orientation are more likely to see feedback as an opportunity to learn more about themselves and a valuable lesson in self-awareness (Baumeister 2007).

An organisation's feedback culture will also shape how far the person sees 360 degree feedback as an opportunity to learn and grow. If there is a climate for learning, feedback is more likely to be considered and accepted (Atwater and Waldman 1998). Well-informed processes, structures and support mechanisms for formal and informal feedback signal a culture of learning to employees. As a result, when feedback is given it is received as well-meaning and developmental (London and Smither 2002).

It is hard to establish the effects of 360 feedback on leadership effectiveness in isolation. Nonetheless this evidence may suggest the importance of using 360 feedback interventions as a first step in an individual's development plan. Step 2 can then consist of open, transparent and safe feedback channels, and Step 3 comprise action to celebrate an individual leader's strengths and address development needs.

Other useful material

360 degree feedback, best practice guide.

ptc.bps.org.uk/sites/ptc.bps.org.uk/files/Documents/Guidelines%20and%20Information/360%20degree%20feedback%20best%20practice%20guidelines.pdf

Developed by the Chartered Institute of Personnel and Development, South West London Branch, SHL, The British Psychological Society, The Department of Trade and Industry and The University of Surrey Roehampton.

360 degree at Royal Bournemouth and Christchurch NHS Foundation Trust

The trust used 360 degree feedback with its executive team, using a model based on the collective leadership approach described in the culture and leadership programme. The team was keen to do this as the approach resonated with its work on culture and with the trust's values. Team members found it valuable and linked it with their appraisal process. Senior leaders across the trust are now interested in spreading the approach through the organisation.

Figure 1: Leadership model underpinning Bournemouth's 360 degree approach

References

Alimo-Metcalfe B (1998) 360 degree feedback and leadership development. *International Journal of Selection and Assessment* 6 (1): 35–44

Atwater L, Waldman D (1998) 360 degree feedback and leadership development. *The Leadership Quarterly* 9 (4): 423–426

Bass BM, Avolio BJ (1994) Improving organizational effectiveness through transformational leadership. Sage, London

Baumeister RF, Vohs KD, Nathan DeWall C, Zhang L (2007) How emotion shapes behavior: feedback anticipation and reflection rather than direct causation *Personality and Social Psychology Review* 11 (2): 167–203

Fletcher C (2008) Appraisal, feedback and development: making performance review work. Routledge, London

Fletcher C (2001) Performance appraisal and management: the developing research agenda. *Journal of Occupational and Organizational Psychology* 74 (4): 473–487

Kluger AN, DeNisi A (1996) The effects of feedback interventions on performance: a historical review, a meta-analysis, and a preliminary feedback intervention theory. *Psychological Bulletin* 119 (2): 254–284

London M, Smither JW (2002) Feedback orientation feedback culture and the longitudinal performance management process. *Human Resource Management Review* 12 (1) 81–100

Maurer TJ Mitchell DR, Barbeite FG (2002) Predictors of attitudes toward a 360-degree feedback system and involvement in post-feedback management development activity. *Journal of Occupational and Organizational Psychology* 75 (1) 87–107

Rosti Jr RT, Shipper F (1998) A study of the impact of training in a management development program based on 360 feedback. *Journal of Managerial Psychology* 13 (1/2): 77–89

Seifert CF, Yukl G, McDonald RA (2003) Effects of multisource feedback and a feedback facilitator on the influence behavior of managers toward subordinates. *Journal of Applied Psychology* 88 (3): 561

Thach EC (2002) The impact of executive coaching and 360 feedback on leadership effectiveness. *Leadership & Organization Development Journal* 23 (4): 205–214

Van Velsor E, McCauley CD, Ruderman MN (eds) (2010) The Center for Creative Leadership handbook of leadership development (122) John Wiley & Sons, San Francisco, CA

Measuring compassion

As a core value of the NHS, it is vital we measure performance in terms of compassion, to chart progress and compare results with other organisations.

What is it?

Compassion can be understood as having four components:

- attending
- understanding
- empathising
- helping.

In the context of an interaction between a healthcare professional and – for example – an elderly patient, these components might involve the following actions:

- attending – paying attention to the other and noticing their suffering
- understanding – understanding what is causing the other's distress by appraising the cause
- empathising – having an empathic response, a felt relation with the other's distress
- helping – taking intelligent (thoughtful and appropriate) action to help relieve the other's suffering.

Measuring compassion performance involves assessing the extent to which an individual displays compassionate performance in their work.

Why is it important?

The NHS was founded in 1948 on the basis of the core value of compassion. The post-war generation made a commitment to providing care for all those who needed it, regardless of status, wealth, ethnicity, age or gender. The very founding of the NHS was an expression of compassion as a core national value. Today, most NHS staff have at some point decided to dedicate a major part of their lives to caring for others. So compassion is the core work value of virtually all NHS staff.

In organisations where the core value is compassion, staff motivation, wellbeing and effort are sustained and nurtured. Compassionate care is also what patients want. For these reasons, it is important to assess the extent to which compassion is demonstrated in the performance of individual team members, the team as a whole and as a property of the organisation's culture.

Through these processes of measuring and reinforcing the importance of compassion, we can reinforce the core values of the organisation and the NHS as a whole.

Research evidence

There are several methods of assessing compassion but perhaps the simplest is using psychometric measures. However, the academic literature suggests there are no well-established measures of compassion available as yet, though some promising approaches are available.

Barriers to compassion in healthcare

In healthcare, several factors act as barriers or inhibitors of compassion:

- 'shackles of routine and ritual' (Kelly 2007), blamed for constraining compassion by hindering flexible, individualised and creative delivery of patient-centred care
- the complexity of the NHS environment, with its demands created by factors such as regulation, governance protocols, political conflicts and the introduction of competition to stimulate innovation, which can lead to chasing targets and a sense of threat
- fear of making errors
- time pressure
- excessive and often defensive bureaucracy
- bullying
- stress
- depression
- burnout
- rapid change
- workload demands
- poor levels of staffing
- job insecurity
- difficult patients and families
- complex clinical situations.

Sources: Cole-King and Gilbert (2011), de Zulueta (2016), Mannion (2014)

In contrast, compassionate cultures can be nurtured by leaders, and indeed all staff, behaving with compassion. While much of the research on emotions in organisations has focused on the personal impact of an individual's emotions, emotions have influence beyond the individual.

For example, individual group members' affective states can influence the whole team's general mood, a phenomenon known as mood linkage or emotional contagion (Hatfield et al 1992, Totterdell 2000, Totterdell et al 1998).

Similarly, leaders' moods and emotions, given their positions of power and influence in organisations, can influence the moods and behaviours of those with whom they work. Research shows that positive leader affect is associated with more positive affect among employees (Cherulnik et al 2001), enhanced team performance (George 1995) and higher rates of prosocial behaviours (George 1990).

How do you do it?

Measuring compassion at an individual level

The psychometric scale below enables you to measure compassion in individuals based on the four dimensions (attending, understanding, empathising and helping).

The scale can be used by colleagues or followers, or adapted into a self-report measure to be included in assessment and selection methods using multi-rater feedback (gathering ratings from diverse perspectives – see 360 degree feedback).

For new candidates, this may be difficult. An alternative is to use a 'realistic job preview' as part of the selection procedure and to observe the prospective employee's behaviours throughout, scoring each dimension of compassion on a scale of 1 to 5.

Another option is to develop scenarios that offer the opportunity for compassionate response and ask staff to describe what they would do in this situation (see values-based recruitment).

Psychometric scale

	This person...	Score (1–5)*
Attending	listens carefully when exploring problems	
	pays close attention to you when listening	
	is very attentive when you are telling them about difficulties	
	gives you their full attention when you are describing challenges you face	
Understanding	is helpful in understanding the causes of difficulties we face	
	does not impose their understanding of the causes of difficulties we face	
	takes time to understand carefully the causes of problems	
	works together with us to come to an understanding of problems	
Empathising	is genuinely warm and empathic	
	is emotionally in touch with others' feelings when they are upset	
	is sensitive to what others are feeling	
	genuinely cares about others' difficulties	
Helping or serving	helps people practically with problems they face	
	takes effective action to help others with the problems they face	
	deals effectively with problems to help others	
	is genuinely committed to making a difference by serving others	

**Suggested response scale: 1 = never, 2 = rarely, 3 = frequently, 4 = almost always 5 = always*

Source: West and Chowla (2017)

Measuring compassion at the organisational level

Assessing the extent to which health and care organisations have a culture of compassion is valuable because it indicates the strength of compassion across the organisation. This involves assessing particularly the behaviour of leaders and managers, but also the behaviour of staff generally.

Tools available on the market include the Cultural Assessment Tool (CAT), developed by Aston OD in co-operation with The King's Fund, measures the extent to which managers:

- promote supportive, warm relationships
- express appreciation for people's contributions
- remove obstacles to effective working
- avoid blame
- take the time to support, consult with and listen carefully to people's concerns at work.

The tool also assesses the extent to which compassion characterises an organisation's culture: between staff and patients, between staff, and between managers (or leaders) and staff.

The cultural assessment tool

		Score (1–5)*
Support	The following statements relate to levels of support provided by managers and leaders in your workplace. How strongly do you agree or disagree with the following statements?	
	1. Managers and leaders encourage warm, supportive relationships among staff	
	2. Managers and leaders recognise and celebrate good performance	
	3. Managers and leaders deal effectively with problems that get in the way of our work	
	4. My manager listens carefully to staff to find out how to support them effectively	
	5. My manager is very compassionate towards staff when they face problems	
	6. My manager is highly empathic in their dealings with members of staff	
Compassion	The following statements relate to levels of compassion shown to and demonstrated by people in your workplace. How strongly do you agree or disagree with the following statements?	
	7. People here are very compassionate towards colleagues when they face problems	
	8. People here give good support to colleagues who are distressed	
	9. People here are very compassionate in the way they behave towards patients/service users	
	10. People here are very compassionate in the way they behave towards patients/service users	

**Suggested response scale: 1 = never, 2 = rarely, 3 = frequently, 4 = almost always 5 = always*

References

Cherulnik PD, Donley KA, Wiewel TSR, Miller SR (2001). Charisma is contagious: the effect of leaders' charisma on observers' affect. *Journal of Applied Social Psychology* 31 (10): 2149–2159

Cole-King A, Gilbert P (2011) Compassionate care: the theory and the reality. *Journal of Holistic Healthcare* 8 (3): 29–37

de Zulueta PC (2016) Developing compassionate leadership in health care: an integrative review. *Journal of Healthcare Leadership* 8: 1–10

George JM (1990) Personality, affect, and behavior in groups. *Journal of Applied Psychology* 75 (2): 107

George JM (1995) Leader positive mood and group performance: the case of customer service. *Journal of Applied Social Psychology* 25 (9): 778–794

Hatfield E, Cacioppo JT, Rapson LR (1992) Primitive emotional contagion. In M. S. Clark MS (ed) Review of personality and social psychology: emotion and social behavior (14): 151–177. Sage, Newbury Park, CA

Kelly J (2007) Barriers to achieving patient-centered care in Ireland. *Dimensions of Critical Care Nursing* 26 (1): 29–34

Mannion R (2014) Enabling compassionate health care: perils, prospects and perspectives. International *Journal of Health Policy & Management* 2 (3): 115–117

Totterdell P (2000) Catching moods and hitting runs: mood linkage and subjective performance in professional sport teams. *Journal of Applied Psychology* 85 (6): 848

Totterdell P, Kellett S, Teuchmann K, Briner RB (1998) Evidence of mood linkage in work groups. *Journal of Personality and Social Psychology* 74 (6): 1504

West A, Chowla R (2017) Compassionate leadership for compassionate healthcare in Gilbert P (ed) Compassion: concepts, research and applications, Routledge, Oxford: 237–257

Additional useful resources

Further resources which will help your work in this area

NHS Employers: People and Performance Management toolkit contains sections on objective setting, reviewing employee performance and feedback.
www.nhsemployers.org/case-studies-and-resources/2017/04/people-performance-management-toolkit

The NHS Leadership Academy: The Edward Jenner on line programme covers a range of topics including: Levels of listening, giving and receiving feedback. This is accessible to all NHS staff following a short registration process:
www.leadershipacademy.nhs.uk/programmes/the-edward-jenner-programme/

The NHS Leadership Academy's Health Care Leadership Model and supporting resources can be found here:
www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/

ACAS How to manage performance also contains guidance on feedback:
www.acas.org.uk/index.aspx?articleid=2927

Case Study 6

Who
Northamptonshire Healthcare NHS Foundation Trust

Programme name
Leadership matters

What was the aim?

The Care Quality Commission rated Northamptonshire Healthcare NHS Foundation Trust as 'requires improvement' under the 'well-led' domain in 2015. This resulted in organisational change, and the reduction in the number of leaders. Research in the trust found many leaders moving into managerial roles from clinical roles with little or no training or experience. It was therefore evident that we needed to develop those in leadership roles.

What did they do?

We started the 'Leadership matters' programme to introduce a leadership behavioural framework and develop a culture in which managers know the organisation's core priorities. We implemented the framework through a new appraisal process, regular 'Leadership matters' conferences and the 'Leadership matters' training programme.

Behavioural framework

The leadership behavioural framework was designed as part of a new appraisal process and to set clear expectations for the leadership behaviours we wanted to see across the organisation.

The framework is divided into four themes:

- working together
- taking responsibility
- being authentic – 'we demonstrate fairness and integrity in everything we do'
- embracing change.

These are a central feature of the appraisal process and are discussed in the appraisal conversation. Feedback on appraisal was poor previously so we wanted the new approach to reflect the organisational culture we aspired to, enable robust talent management and be aligned to organisational strategy.

'Leadership matters' conferences

The 'Leadership matters' conferences were designed to be delivered regularly with leaders from across the organisation. The initial conference introduced the leadership behavioural framework. Subsequent conferences each focused on different topics:

- quality leadership – where are we now
- clinical leadership – moving to good and beyond
- healthy teams
- changing the lens – diversity and inclusion
- team excellence.

'Leadership matters' training programme

We reviewed the content and delivery methods of the organisation's leadership programmes, redesigning and branding them as part of 'Leadership matters'.

All redesigned modules incorporated a 'brain-based learning' methodology; based on using reasoning, sound, vision and physicality to enable staff to retain information for longer. The modules aimed to turn information sharing into learning, and make use of experiential learning. The leadership behaviours were embedded into all modules, and the training was made mandatory for all leaders in the organisation.

We selected the modules' content based on the organisation's specific needs. For example, the 'managing sickness' module includes specific topics around managing mental health sickness as this is the organisation's main cause of sickness. The modules were divided between 'foundation' – core skills and responsibilities of leaders and managers, and 'engaging' – higher level, people skills:

Foundation	Engaging
Appraisals	Courageous conversations
Disciplinary, capability and grievances	Distributed and systems leadership
Leading change and transition	Empathy
Managing sickness	Leader as coach
Personal effectiveness	Making things happen
Quality, performance and innovation	Negotiating for influence
Recruitment and selection	Resilience for leaders

What were the outcomes?

CQC re inspected the trust in early 2017 and rated it as 'good' overall, including the 'well-led' domain.

- The trust board was described as 'outstanding' for leadership, with inspectors highlighting staff feedback that leaders were "given the opportunity to develop and had good role models in their managers". Inspectors also commented that senior staff had told them leadership behaviours were "embedded in their practice and were displayed across the trust".
- The leadership conferences and 'Leadership matters' modules are continuing to run, with hundreds of attendees.
- The 'Leadership matters' programme is a finalist in the Chartered Institute of Personnel and Development People Management Awards 2017 for best learning and development initiative in the public/ third sector.
- The trust's 2017 Q1 results for the Friends and Family Test have improved, with 68% of staff recommending the trust as a place to work – up 2% from 2016 Q4 and up 8% from 2016 Q1.

What were the learning points?

Cultural change takes time, and changes or improvements may not be immediately recognisable. The programme has a 'slow burning' impact that requires sustaining.

Support and engagement from the executive team and other corporate teams have been vital, ensuring our message is consistent across the trust. We continue to use multifaceted communication to promote the message and brand of 'Leadership matters' across the organisation, particularly the leadership behaviours.

For further information please contact:
Anne.Linsell@nhft.nhs.uk

While this organisation did not use NHS Improvement's culture toolkit, it created its own culture journey to ensure improvements were made, acknowledging the importance to the NHS of developing compassionate and inclusive cultures.

Case Study 7

Who
Sheffield Teaching Hospitals NHS Foundation Trust

Programme name
The positive contribution of young people with learning disabilities in the workplace

What was the aim?

Sheffield Teaching Hospitals NHS Foundation Trust wanted to help young people with learning disabilities gain significant work experience and references from placement managers so they could build their confidence at work and find employment locally.

The *Sheffield learning disability health needs assessment 2016* noted it was hard to say how many people in the city had a learning disability as definitions had changed over time, but we estimated that 12,000 had a learning disability or difficulties.

What did they do?

In 2016 we worked with Sheffield College to set up a supported 42-week internship programme for young adults with learning disabilities who were 16 to 24 years old. Candidates had to have an education and healthcare plan, and have completed a variety of college courses as well as a successful work experience placement. Sheffield College identified candidates as ready for employment and referred them to the internship programme.

Learners attended Sheffield College two days a week for the first eight weeks, then two afternoons a week for the next 34 weeks. During this time they completed preparation for work sessions and studied Level 1 work skills, maths for work and English for work.

During the 34-week period, interns were on placement in the trust for 20 hours a week, 8:30am to 12:30pm daily. Interns rotated placements to vary their work experience. This consisted of three eight-week placements in supplies, laundry, catering or administration and one five-week placement in domestic services.

Placements were offered in job roles considered to have a workforce need. We provided a bespoke induction to the trust, which included:

- a mock assessment centre and one-to-one interview (values-based recruitment)
- trust values and behaviours
- trust policies and procedures
- mandatory training
- guided tour around the trust's hospital sites
- visits to placement areas
- ID badge/uniform allocation.

Linda Crofts, Head of Learning and Development, said: "We are pleased to be working with the college to provide these opportunities for young people to gain important experience in the world of work. They are performing valuable roles in their areas and we hope the experience should stand them in good stead to gain employment in the future".

Heather Smith, Principal of Sheffield College, said: "Students with learning difficulties and disabilities

can face barriers to employment. Our recently launched supported internship programme helps them to overcome those challenges so students gain the personal, communication and work skills to succeed. We are delighted that such a large regional employer is supporting our scheme, which will help transform lives and enhance our students' long-term employment prospects".

What were the outcomes?

- Six supported interns started the programme and all completed it.
- We recruited two interns to jobs in the trust, and a further two interns are currently in the recruitment process.
- The remaining interns used their experiences and references to gain training and/or further experience elsewhere in the region.
- We held discussions about offering support through complicated NHS recruitment processes and assessment centres. We will continue discussions on how to improve our accessibility so that hard-to-reach groups can apply for jobs with the trust.
- Staff in placement areas had a positive attitude: 86 completed autism awareness sessions in the six placement areas. Jeff Swallow, Catering Manager, said: "We wanted to support this initiative as a department and were delighted about the response from staff who volunteered to work with the interns. Staff in the catering department have shown their support and encouragement of each other and their willingness to engage with the initiative".

What was the learning?

- Gain executive-level support for the supported internship programme.
- Gain support from placement areas and provide training and skills for staff to deliver a successful and positive work experience placement.
- Create and maintain a strong working relationship with your delivery partners.
- Continually evaluate the programme.

For further information please contact:
Amanda.Kearsley@sth.nhs.uk

NHS Improvement

- Compassion-based recruitment
- Developing compassionate leadership
- Developing emotional intelligence
- Inclusion: listening to all voices
- Coaching
- Mentoring
- Inclusive leadership development
- Diversity and equal opportunities training
- Compassionate behaviour training
- Identity-based talent management

Compassion-based recruitment

Prioritising compassion right from the start of the selection progress helps identify staff whose values are aligned with organisational values.

What is it?

Recruiting and selecting for compassion is an approach to finding employees whose personal values and behaviour align with the organisation's core value of compassion. The process highlights candidates whose values and behaviour indicate a strong orientation of compassion towards others. Having this as a named process also communicates the organisation's commitment to the core value of compassion at an early stage in the potential employee's involvement with the organisation.

Why is it important?

Compassion-based recruitment seeks to ensure that staff have not only the right skills, but the right value of compassion to deliver high quality patient care and experience.

Recruitment and selection decisions reinforce to staff at all levels what is important to the organisation and to the NHS. This is especially important where decisions about selection are based on fine-grained academic performance, and compassion is not considered.

Organisations that have a core value of compassion sustain and nurture staff motivation, wellbeing and effort. Compassionate care is also what patients want. So actively maintaining a compassionate orientation across an organisation helps produce a strong culture that affects the outcomes that matter (Dixon-Woods et al 2014, West and Chowla 2017, West et al 2014a).

Find out more

If you are interested in compassion in the context of the NHS, it is important that you also read these entries: Developing compassionate leadership, Compassionate behaviour training.

What is the evidence?

Leaders set an important tone for the value and legitimacy of noticing suffering at work and responding compassionately (Dutton et al 2006). Kanov et al (2004) argue that 'organisational compassion' can be developed where there is collective noticing or acknowledging of pain within a system that values this noticing.

Beyond the impact that compassion has on individuals, it has the potential to spiral out: those receiving compassion are better able, or more likely, to direct caring and supportive behaviours towards others (Lilius et al 2011). This replenishes the emotional resources that caregivers need – especially in a caring environment – and cushions against stress and burnout (Lilius et al 2011, Dutton et al 2014).

When an individual experiences compassion from others, it shapes their appraisal of:

- themselves (for example, seeing themselves as more capable)
- their peers (viewing them as more kind)
- the kind of organisation they are part of (Dutton et al 2014).

When staff feel valued and cared for (in other words, perceived organisational support), they tend to feel more satisfied with their jobs and more committed to their organisations (Lilius et al 2011). There is considerable evidence that this is true in the NHS. Organisational support is associated with high levels of patient satisfaction, care quality and even financial performance in healthcare organisations (West et al 2011).

Receiving compassion in the workplace benefits staff and the organisation alike. It leads to people experiencing more positive emotions, such as gratitude, pride and inspiration, and more upward emotional spirals that enhance emotional wellbeing (Lilius et al 2008). It helps communicate dignity and worth, and helps people feel better psychologically connected with others (Dutton et al 2014).

The theory of positivity resonance explains how moments of connectivity (such as interpersonal compassion) benefit people in an interaction through a natural synchronisation of bodies and brains, in ways that foster health and wellbeing (Fredrickson 2013). Compassion also creates a sense of being valued at work (Dutton et al 2014).

Research has clearly revealed the importance of ensuring a fit between the values of the organisation and of new staff – so-called 'person-organisation fit'. The better the fit, the more committed new employees are to their organisations, and the longer they stay. This is especially true during periods of organisational change (Meyer et al 2010, De Cooman et al 2009).

Given the difficulties of attracting and retaining staff in the NHS, it is vital to use the recruitment process to emphasise the core organisational value of compassion that matters to staff generally, and to the organisations that make up our healthcare system, to ensure high quality, compassionate care (West et al 2014b).

How does it work?

Essentially, this approach involves recruiting and selecting partly on the basis of the individual's compassionate values and behaviours. Assessing for compassion signals one of the organisation's core values to applicants, saying: 'Compassion is an important competency here'. This forms part of the socialisation process and is a signal to the prospective employee of organisational culture before they even enter the organisation

One way of doing this is to include a psychometric scale in assessment and selection methods by asking the candidate to gather ratings from diverse perspectives. For new candidates, this may be difficult. You may wish to use a realistic job preview as part of your selection procedures and observe the behaviour of the prospective employee throughout, scoring them on a scale of one to five.

The compassion measure tool measures the four dimensions of compassion: attending, understanding, empathising and helping. These can be rated by co-workers or followers, or adapted as a self-report measure.

Compassion measure

		Score (1–5)*
Attending	Listens carefully to others when exploring problems	
	Pays close attention to you when listening	
	Is very attentive when you are telling them about difficulties	
	Gives you their full attention when you are describing challenges you face	
Understanding	Is helpful in understanding the reasons for difficulties we face	
	Does not impose their understanding of the cause of difficulties we face	
	Takes time to understand carefully the causes of problems	
	Works together with us to come to an understanding of problems	
Empathising	Is genuinely warm and empathic	
	Is emotionally in touch with others' feelings when they are upset	
	Is sensitive to what others are feeling	
	Genuinely cares about others' difficulties	
Helping	Helps people practically with problems they face	
	Takes effective action to help others with the problems they face	
	Deals effectively with problems to help others	
	Is genuinely committed to making a difference in helping others	

**Response scale: 1 = never, 2 = rarely, 3 = frequently, 4 = almost always 5 = always*

During recruitment, those responsible for making decisions explore compassion among potential recruits in ways such as:

- pre-screening assessments
- interviewing techniques such as structured interviews, role play or responses to scenarios
- assessment centre approaches
- psychometric instruments
- situational judgement tests.

In practice, recruiting for compassion may involve adding to the interview questions such as those in the box below.

Sample compassion-based interview questions

To test for support and compassion towards patients

'Tell us about a time when you worked with a patient in distress. How did you go about the process?'

Key criteria: attending, understanding, empathising, helping.

To test for support and compassion towards colleagues

'Tell us about a time when you worked with a colleague who was angry with you. How did you go about managing the situation effectively?'

Key criteria: attending, understanding, empathising, helping

To test for commitment to compassion in teamworking and collaboration

'Tell us about how you feel you work particularly well with colleagues who are under pressure in teams and the way you make a contribution.'

Key criteria: building cohesion, support, optimism, efficacy

To test for commitment to compassion in working with those in other professions

'Tell us about a time you worked with someone from another professional group and there was some tension or conflict. How did you deal with this?'

Key criteria: listening, understanding, empathising, helping, building cohesion, support

'Give an example of a time when you encouraged and enabled collaboration between your team and another team or department.'

Key criteria: working effectively across boundaries, prioritising patient care overall (not only within team performance)

Tips

- Compassion-based approaches to recruitment work best if they are implemented effectively and comprehensively. This means making sure that much of the questioning in an interview, for example, is focused on compassion issues and that these play a major role in determining selection.
- Leaders need training to conduct effective compassion-based recruitment. The more objective the approach to selection, the better. So where good psychometric measures of compassion exist, it makes sense to use them.
- Structured interviews are much more effective than unstructured interviews, as are work sample tests (Schmidt and Hunter 1998). Using scenarios to test for compassion is also helpful: 'How would you react in this situation?'
- Recruitment is just one stage of the employment journey, so it must form part of an holistic approach that ensures compassion is embedded in all areas of employment practice, from training and appraisals through to organisational development.
- When interviewing or observing, make sure more than one person is present to rule out any unconscious biases that may influence the way a person is assessed.

See also Equal opportunities training, Compassionate behaviour training and Values-based recruitment

References

De Cooman R, De Gieter S, Pepermans R, Hermans S, Du Bois C, Caers R, Jegers M (2009) Person–organization fit: testing socialization and attraction–selection–attrition hypotheses. *Journal of Vocational Behavior* 74 (1): 102–107

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23 (2): 106–115

Dutton JE, Workman KM, Hardin AE (2014) Compassion at work. *Annual Reviews of Organizational Psychology and Organizational Behaviour* 1 (1): 277–304

Dutton JE, Worline MC, Frost PJ, Lilius J (2006) Explaining compassion organizing. *Administrative Science Quarterly* 51 (1): 59–96

Fredrickson B (2013) Love 20: how our supreme emotion affects everything we feel, think, do, and become. Hudson Street Press, New York

Kanov JM, Maitlis S, Worline MC, Dutton JE, Frost PJ, Lilius JM (2004) Compassion in organizational life. *American Behavioral Scientist* 47 (6): 808–827

Lilius JM, Worline MC, Maitlis S, Kanov JM, Dutton JE, Frost P (2008) The contours and consequences of compassion at work. *Journal of Organizational Behavior* 29: 193–218

Lilius JM, Kanov J, Dutton JE, Worline MC, Maitlis S (2011) Compassion revealed: what we know about compassion at work (and where we need to know more). In Cameron K, Spreitzer G (eds) The Oxford handbook of positive organizational scholarship. Oxford University Press, New York

Meyer JP, Hecht TD, Gill H, Toplonytsky L (2010) Person-organization (culture) fit and employee commitment under conditions of organizational change: a longitudinal study. *Journal of Vocational Behavior* 76 (3): 458–473

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In Gilbert P (ed) Compassion: research and application. London: Routledge: 237–257

West MA, Dawson JF, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 28 July 2017)

West M, Lyubovnikova J, Eckert R, Denis JL (2014a) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1 (3): 240–260

West MA, Topakas A, Dawson JF (2014b) Climate and culture for health care performance. In Schneider B, Barbera KM (eds) The Oxford handbook of organizational climate and culture. Oxford University Press, Oxford: 335–359

Developing compassionate leadership

For compassion to play a core role in organisational culture, leaders must model the behaviours and values they want to see in their staff.

What is it?

Developing compassionate leadership involves developing the knowledge, skills, attitudes and values of leaders at every level, so they model compassion in how they lead. Compassionate leaders learn to:

- attend to the people they lead
- understand the challenges they face
- empathise with them
- take action to serve or help them.

Each of these is explained below.

Attending

Our attention is directed by whatever motivates us. So focused leaders will pay attention in a particular way to those they lead – what Nancy Kline (2002) calls 'listening with fascination'. In practice, this involves taking the time to listen to the accounts of the experiences of staff throughout their work: the challenges, obstacles, frustrations and hurts as well as the successes and delights. So the first and most important task for leaders is to devote adequate time to listening deeply to their staff, to appreciate the situations they face and their ability face them.

Understanding

This involves leaders appraising the situation their staff face and understanding the causes of their difficulties or distress. Ideally, this is best done with the individual, and their distress will invoke compassion. This is because a shared understanding is likely to be both more accurate and helpful for the distressed person.

Empathising

We are uniquely enabled as a species to feel others' distress because of our neurophysiological capacity to mirror observed emotion. So a leader who is compassionate is emotionally in touch with others' distress. They are able to tolerate the distress, while not over-identifying with it. This mirroring partly enables leaders to arrive at a deeper understanding of the other's situation and provide the motivation to serve or help them.

Helping

This involves taking thoughtful and intelligent action to serve or help the other. Leaders need wisdom to know what this involves. It could be removing obstacles, helping implement solutions or taking thoughtful, appropriate action such as simply listening. Four subcomponents are required for a competent compassionate response:

- scope – breadth of resources offered
- scale – the volume of resources
- speed – the timeliness of the response
- specialisation – the extent to which the response meets the sufferer's real needs.

Why is it important?

Compassionate leadership is the appropriate model of leadership for organisations that have compassion as a core value, such as healthcare organisations.

These four domains of compassionate leadership are particularly powerful in healthcare, where the

workforce is largely composed of highly skilled and motivated professionals who are intent on doing their jobs to the highest possible standard. They are motivated to help others, having selected healthcare as a vocation, and are generally highly trained and skilled. So they need support rather than direction, and enabling rather than controlling interventions, from leaders (West and Chowla 2017).

When leaders demonstrate compassion, they provide support consistent with the core values of the people they lead. This legitimises compassion as an endeavour worthy of valuable time and organisational resources. In turn it encourages and empowers those they lead to respond compassionately in the face of suffering.

When staff can offer compassion through their work, patients are happier with the treatment they receive, which in turn affects staff satisfaction and wellbeing, creating a virtuous cycle of compassion.

So to meet the challenges healthcare faces, it is essential we create cultures of compassion in our organisations. And that requires developing compassionate leadership.

Find out more

If you are interested in compassion in the context of the NHS, it is important that you also read these entries: Compassionate behaviour training, and Compassion-based recruitment.

What is the evidence?

There is no evidence of how developing compassionate leadership directly affects NHS performance. But there is clear evidence that each of the components of compassionate leadership, described above, plays a powerful role in helping to nurture cultures of high quality, continually improving and compassionate care (Dixon-Woods et al 2014, West et al 2014).

In the best-performing healthcare organisations, compassionate leaders (from the top to the front line) make it clear that high quality, compassionate care is the core organisational purpose and priority (Dixon-Woods et al 2014). It also requires compassionate performance management, by negotiating and agreeing clear, aligned and challenging objectives for teams at all levels, focused on providing this care (West 2012). This is quite different from using target-driven cultures to drive change – an approach that has limited success (Ham 2014).

Where health service staff report they are well and compassionately led, patients say they too are treated with respect, care and compassion (Dawson et al 2011). Directive, brusque managers dilute their staff's ability to make good decisions, deplete their emotional resources and hinder their ability to relate effectively to patients, especially those who are most distressed or difficult (Carter and West 1999, Mickan and Rodger 2005, West 2012).

Research in the NHS has shown that learning and innovation are more likely to take place in a culture of compassionate leadership and psychological safety rather than a blame culture (Edmondson 1999, West et al 2017). A culture of supportive teams with compassionate team leadership is linked with reduced levels of stress, errors, staff injuries, harassment, bullying and violence against staff, staff absenteeism and (in the acute sector) patient mortality (Lyubovnikova et al 2015).

How does it work?

To develop compassionate leadership, leaders need to build their compassionate leadership skills in the four domains of compassion described above (attending, understanding, empathising and serving or helping). This can be done in a number of ways – for example:

- attending – mindfulness, active and reflective listening, listening with fascination

- understanding – reflective listening, appreciative inquiry, coaching skills
- empathising – emotional intelligence development
- serving/helping – co-design, coaching skills

NHS England has produced guidance on developing compassion and self-mastery called Building and strengthening leadership: leading with compassion (NHS England 2014):

www.england.nhs.uk/wp-content/uploads/2014/12/london-nursing-accessible.pdf

NHS England's guidance says that enabling leaders to respond to others' needs involves building self-awareness, resilience, mindfulness and emotional intelligence. It includes examples of practices that NHS organisations recommend, such as:

- leaders consciously building a network of optimistic, affirming and appreciatively challenging people
- supporting themselves with relationships with kind and positive people
- encouraging leaders to make the time and space to listen to staff and patient experiences
- practising the skills of standing back, observing and reflecting
- committing to one's own development by attending mindfulness courses or accessing coaching or mentoring for themselves
- being disciplined about the use of phones and responding to emails (in other words, being present in the activity or meeting rather than distracted).

NHS England recommends that leaders seeking to develop compassionate leadership adopt mindfulness, emotional intelligence and self-compassion.

Mindfulness

Mindfulness is a way of paying attention to, and seeing clearly, whatever is happening in and around our lives. It will not eliminate pressures that prevent us from behaving with compassion, but it can help us respond to them in a calmer way. It helps us recognise and step away from habitual, often unconscious emotional and physiological reactions to everyday events. This has benefits for physical and mental health and the experience of those around us. It provides us with a well-evidenced approach to cultivating clarity, insight and understanding (Ie et al 2014a, 2014b).

Mindfulness: find out more

http://oxfordmindfulness.org/

https://mbsr.co.uk/

www.mindfulcompassion.com/

Emotional intelligence

Emotional intelligence is the ability to sense verbal and non-verbal patterns of behaviour – for example, when people support your ideas, when they do not, or when they have concerns.

Emotional intelligence relates to being aware of oneself as well as of others. Being aware of one's own internal state, including one's motivations and triggers, provides the opportunity to self-regulate. Recognising and understanding others' emotions helps one to successfully manage relationships, recognising the reciprocity integral to healthy relationships, making time to listen, as well as to share openly.

The simplest definition of emotional intelligence comes from Daniel Goleman's 1996 book Emotional intelligence – why it can matter more than IQ: 'recognising our own feelings and those of others, motivating ourselves, managing emotions well in ourselves and in our relationships'.

Emotional intelligence: find out more

www.londonleadershipacademy.nhs.uk/sites/default/files/uploaded/Introduction%20to%20Emotional%20Intelligence_FINAL_25%2003%202015.pdf

www.evidence.nhs.uk/search?q=emotional+intelligence

Self-compassion

If leaders are to model compassion, they need also to be compassionate towards themselves. This involves paying attention to themselves, understanding their own life situations, practising empathy towards themselves, and compassionately taking wise, kind action to help themselves. This helps them develop the resources and wisdom to be compassionate to others. There are well developed courses and guides for this work (see Germer 2009, Gilbert 2009, Neff 2011).

Self-compassion: find out more

http://self-compassion.org/

Tips

Worline and Dutton (2017) offer guidelines for developing compassionate behaviour that are central to developing compassionate leadership:

Attending

- Noticing suffering at work
- Inquiring, which is crucial to awakening compassion
- Recognising time pressure, overload and performance demands – these distract us from noticing suffering at work
- Policies, rules and norms of conduct can orient us towards blame and punishment rather than curiosity about what is happening with the other person
- Presence and mindfulness are vital

Understanding

- Suffering is often masked by missed deadlines, errors or difficult and ambiguous work situations that trigger blame instead of compassion
- Leaders can learn to be curious about the causes of difficult or ambiguous work situations as a way of cultivating more generous interpretations
- All leaders can practise cultivating the positive default assumption that others are good, capable and worthy of compassion – offering the benefit of the doubt
- Leaders can withhold blame by steering conversations about errors towards learning
- We can imbue others with dignity and worth no matter what their role, position or difference from us
- We can cultivate presence with suffering as a form of being authentic with others

Empathising

- Fostering mindfulness is hugely powerful – an awareness of changing conditions in ourselves and others on a moment-to-moment basis. It helps us remain calm and steady in the face of suffering – our own as well as others
- We can cultivate the capacity for attunement, which involves being aware of another person while simultaneously staying in touch with our own somatic senses and experiences. We can heighten the sense of interconnection
- We can develop empathic listening, the capacity to tune in to feelings of concern as we hear others' perspectives and experiences. This allows us to be present without necessarily needing to fix, solve or intervene
- Empathy at work helps us 'feel our way forward' together and motivates compassion
- Identifying with others leads to empathy and a higher likelihood of compassionate action
- Feeling similar to the other contributes to identification
- Physical and psychological presence, conveyed through eye contact, verbal tone, posture and facial expressions, heighten identification

It is also important to assess the extent to which leaders are modelling compassionate leadership behaviours. Leadership compassion can be measured using the compassion measure tool, which measures the four dimensions of compassion: attending, understanding, empathising and helping. These can be rated by co-workers or followers, or adapted as a self-report measure.

Helping

- Compassionate action involves spontaneity and improvisation and is directed by what is most useful for those who are suffering
- Skilful compassion involves taking action that addresses suffering
- This includes creating flexible time to cope with suffering, buffering someone from task overload, monitoring and checking in, generating resources that will alleviate suffering and designing rituals that convey support
- Compassionate action can be hindered by legalistic approaches that deny human connection
- Corrosive politics, toxic interactions, consistent underperformance and other forms of conflict at work are sources of suffering that must be addressed. They require 'fierce compassion'
- Compassion is reduced when people fear they will be viewed as weak or vulnerable for giving or receiving compassion
- Importance of integrity and privacy

Adapted from Worline MC, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler, Oakland CA

References

Carter AJW, West MA (1999) Sharing the burden: teamwork in health care settings. In Firth-Cozens J, Payne R (eds). Stress in health professionals: psychological causes and interventions. Wiley, Chichester: 191–202

Dawson JF, West MA, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed on 28 July 2017)

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2014) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23 (2): 106–115

Edmondson A (1999) Psychological safety and learning behavior in work teams. *Administrative Science Quarterly* 44 (2): 350–383

Germer CK (2009) The mindful path to self-compassion: freeing yourself from destructive thoughts and emotions. Guilford Press, New York

Gilbert P (2009) The compassionate mind. Constable, London

Ham C (2014) Reforming the NHS from within. Beyond hierarchy, inspection and markets. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/reforming-the-nhs-from-within-kingsfund-jun14.pdf (accessed 28 July 2017)

Ie A, Ngnoumen CT, Langer EJ (2014a) The Wiley Blackwell handbook of mindfulness vol 1. Wiley Blackwell, Chichester

Ie A, Ngnoumen CT, Langer EJ (2014b) The Wiley Blackwell handbook of mindfulness vol 2. Wiley Blackwell, Chichester

Kline N (2002) Time to think: listening to ignite the human mind. Cassell, London

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24 (6): 929–950

Mickan SM, Rodger SA (2005) Effective health care teams: a model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care* 19 (4): 358–370

Neff K (2011) Self compassion. Hachette, London

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In Gilbert P (ed) Compassion: concepts, research and applications. Routledge, London

West M, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance*, 1 (3): 240–260

West MA (2012) Effective teamwork: practical lessons from organizational research. Third edition. Blackwell Publishing, Oxford

Worline MC, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler, Oakland CA

Developing emotional intelligence

Cognitive skills such as memory and problem solving play an important role in any workplace, but today's healthcare sector needs emotional intelligence too, to ensure high quality interactions not only with colleagues but with patients/service users.

What is it?

Developing emotional intelligence is about helping leaders to improve their emotional quotient (EQ) by:

- knowing their emotions
- managing their emotions
- motivating themselves
- recognising and understanding other people's emotions
- managing relationships.

Compassion is at the heart of all these behaviours. Developing emotional intelligence is not about learning how to manipulate or manage impressions and feign interpersonal connections. This type of 'surface acting' erodes the trust of staff working with such leaders. Instead, it is about understanding ourselves and others and managing relationships in a caring, sensitive, intelligent and supportive way.

Why is it important?

As in all other organisations, staff in the NHS look to leaders to gauge emotional cues, as they are more visible and engage in more interactions with different types of staff. If leaders set a tone of positivity, empathy, reflection and honesty, staff are more likely to have greater resilience, efficacy, hope and optimism. This, in turn, will improve the quality of interactions they have with other staff and, importantly, the patients they serve.

So developing the capacity to self-regulate emotion is a critical competency for leaders in the NHS. Those with stronger emotional intelligence are skilled in their mastery of different leadership styles. Through a deeper understanding of self and greater attentiveness to others, emotionally intelligent leaders can switch between leadership styles, depending on the situation.

What is the evidence?

Historically, intelligence was only thought of as intelligence quotient (IQ): the level of cognitive ability, including memory and problem solving. Over the years, there has been a move away from this definition of intelligence towards non-cognitive factors that may influence performance in the workplace, such as emotional intelligence (EI).

Research shows that when leaders foster positive climates, they are better able to draw out the best in others –particularly those who work directly with them (Goleman et al 2013).

Although Goleman pioneered the area of EI, other researchers and practitioners built the business case for developing EI in the workplace. Martin Seligman showed the importance of optimism in preserving wellbeing, as well as on improving performance (Seligman 2011). Luthans et al (2007 gathered evidence in support of 'psychological capital' (PsyCap), considered to combine resilience, optimism, efficacy and hope.

Overall, the value of EI in the workplace is well demonstrated in research (for example, George 2000; Slaski and Cartwright 2002).

Useful case studies show the value of developing EI in the workplace. For example, after supervisors in a manufacturing plant received training in emotional competencies, such as how to listen better and help employees resolve problems on their own, lost-time accidents were reduced by 50%, formal grievances from an average of 15 to three per year, and the plant exceeded productivity goals by US$250,000 (Pesuric and Byham 1996).

In another example, the US Air Force used EI to select recruiters, as it found that the most successful recruiters scored significantly higher in EI. The immediate gain was a saving of US$3 million annually. The Center for Creative Leadership found that the primary causes of derailment in executives involve deficits in emotional competence. The three primary causes are difficulty in handling change, not being able to work well in a team and poor interpersonal relations (Leslie and Van Velsor 1996).

How is it done?

Organisations that develop emotional intelligence integrate the EI philosophy into their developmental interventions and strategies such as appraisals, 360 degree feedback and goal setting. Using compassion-based approaches is similar, and the two approaches are likely to be complementary. Compassion training also emphasises the element of serving or helping, which is important in healthcare contexts.

Embedding EI development into other HR or OD activities typically requires encouraging leaders to ask:

- 'Who do I want to be?'
- 'Who am I?'
- 'How can I build my strengths while reducing my gaps?'
- 'How can I embody EI in behaviours, thoughts and feelings?'
- 'How do I build closer, supportive and trusting relationships that facilitate change?'

Steps to build emotional intelligence in your staff

1. My ideal self – who do I want to be?

Ask 'Where do I want to be 15 years from now?' and write it down.

Goleman et al suggest that envisioning your best possible self in the future and writing it down creates a goal and commitment to it. Be encouraged to write down the values, beliefs and principles that underpin that vision of self.

2. My real self – who am I?

Ask 'What are your strengths and gaps?'

Goleman et al highlight how easy it is for us to become overly comfortable in our current state and lose sight of who we really are. 360 degree evaluations support this self-discovery by gathering multiple perspectives on individuals – namely, those who work in close proximity with us, such as our manager, peers and people who report to us.

3. My learning agenda – how can I build on my strengths while reducing the gaps?

- A learning plan is a good way to motivate and direct staff towards their 'ideal self'. It is critical that the employee agrees the learning plans and goals.
- All learning goals should be clear, specific and timely, and feedback on progress towards them is important.
- These learning goals can be included in appraisals or in ongoing conversations with supervisors or people who report to you. Although they are developmental, all learning goals should come with success criteria to evaluate the extent to which employees are reaching their intended objectives.
- It is important that goals are self-directed, to maximise motivation and persistence to achieve the goal.

4. **Mastery – How can I embody EI in behaviours, thoughts and feelings?**
    - Encourage staff to experiment with and practise new behaviours so they can reach a point of mastery. Give them the space they need to do this. Focus on using active, concrete and experiential methods to build emotional and social competence.
    - In meetings, encourage all staff to 'check in' so they can practise sharing and listening to others' emotions and thoughts.
    - Link learning goals to personal values so there is more authenticity and motivation to master these EI behaviours, thoughts and feelings. The philosophy of developing EI is authenticity and alignment to core values, beliefs and attitudes.
5. **Connections – How do I build closer, supportive and trusting relationships that facilitate change?**
    - Build in support networks that enable regular meet-ups and contact with other staff seeking to develop their EI.
    - During socialisation into the organisation, you may want to 'buddy up' employees so they have some kind of emotional/social support in their first few weeks and months. Pairing employees who may work in contrasting or starkly different roles will set a tone of positivity and support. This will engender an organisational culture naturally oriented towards learning and cross-boundary working.

Psychometric measures to evaluate a person's EI capability

To evaluate the success of your intervention, you need to take baseline and post-programme measures of EI. A positive change (in other words, increased EI capability) would strongly suggest your programme has been successful.

These instruments can be used to assess EI capability:

Bar-On's EQ-I (Bar-On 1997)

- self-report instrument evolved from clinical psychology and designed to assess emotional wellbeing
- strong reliability and convergent and discriminant validity
- a study with US Air Force recruiters showed its predictive validity of improved performance and subsequent financial savings annually.

Multifactor Emotional Intelligence Scale (Mayer et al 2003)

- considered to be more of a test of ability versus self-report
- the test involves performing a series of tasks designed to assess the ability to perceive, identify and work with emotion
- evidence of construct validity, convergent validity and discriminant validity.

Emotional Competence Inventory (Boyatzis and Sala 2004)

- a 360 degree instrument
- measures 18 competencies, including self-awareness, self-management, social awareness and relationship management.

Compassion scale

This scale is useful for evaluating the success of EI intervention or development programmes. The compassion scale will be sufficient for evaluating any intervention designed to increase:

- empathy
- emotional awareness
- compassion
- attentiveness to needs of others
- warmth
- orientation to support.

See more: Compassion based recruitment

Tips

- Integrate the use of EI with compassion development for leaders and all staff.
- Make sure other interventions reinforce the importance of compassion skills such as attending, understanding and helping.
- Integrate evidence about the value of compassion and EI as an element of compassion in presentations to leaders.
- Ensure these approaches are built in to all HR and OD plans.

References

Bar-On R (1997) The emotional intelligence inventory (EQ-I): technical manual. Multi-Health Systems, Toronto

Boyatzis RE, Sala F (2004) Assessing emotional intelligence competencies. In Geher G (ed) The measurement of emotional intelligence. Nova Publishers, Hauppauge, NY

George JM (2000) Emotions and leadership: the role of emotional intelligence. *Human Relations* 53 (8): 1027–1055

Goleman D, Boyatzis RE, McKee A (2013) Primal leadership: unleashing the power of emotional intelligence. Harvard Business Press, Boston MA

Leslie JB, Van Velsor E (1996). A look at derailment today: North America and Europe. Center for Creative Leadership, Greensboro, NC

Luthans F, Avolio BJ, Avey JB, Norman SM (2007). Positive psychological capital: measurement and relationship with performance and satisfaction. *Personnel Psychology* 60 (3): 541–572

Mayer JD, Salovey P, Caruso DR, Sitarenios G (2003) Measuring emotional intelligence with the MSCEIT V2. 0. *Emotion* 3 (1): 97–105

Pesuric A, Byham W (1996). The new look in behavior modeling. *Training and Development*. July: 25–33

Seligman ME (2011). Learned optimism: how to change your mind and your life. Vintage, New York

Slaski M, Cartwright S (2002) Health, performance and emotional intelligence: an exploratory study of retail managers. *Stress and Health* 18 (2): 63–68

Inclusion: listening to all voices

For healthcare organisations to meet the needs of their staff, and of everyone in the communities they serve, they must develop the skills and structures to listen to the voices of everyone who is affected by their work.

What is it?

Inclusion and listening to all voices in healthcare involve ensuring the views and ideas of all staff, patients and the wider community are heard and integrated into the process of developing healthcare. Healthcare can then best meet the community's needs.

In a climate of inclusion everyone is listened to respectfully, positively and with authenticity. This helps provide healthcare of the highest quality that matches the aspirations and expectations of staff, patients and the wider community.

Why is it important?

When staff are consulted, listened to and involved in shaping change, they are more likely to bring wisdom, compassion, intelligence, commitment, courage and emotional intelligence to their work (Worline and Dutton 2017).

Staff are more committed and satisfied when their leaders listen and respond to them. Staff will also be more engaged, and we know that engagement is the strongest staff survey predictor of healthcare organisations' performance : services are likely to be better and resources used more efficiently. Discussions with staff about frontline challenges and problems will generally lead to better solutions (because of their expertise) than when their voices are not heard (West and Dawson 2012).

Listening to all voices is fundamental to collective leadership – a core principle of a positive healthcare culture.

Find out more

If you are interested in diversity in the context of the NHS, it is important you read: Diversity, Identity-based talent management, Inclusive leadership and Diversity and equal opportunities training.

What is the evidence?

Taking the time to listen to all stakeholders (including staff, patients, carers, patient groups, community representatives and other organisations) results in higher levels of successful innovation that improves services and performance (West and Chowla 2017).

Psychological safety

Inclusion, speaking up and listening are more likely to occur in contexts characterised by what Edmondson (1996, 1999) calls 'psychological safety'. She used this term to describe differences between newly formed intensive care nursing teams in the way they managed medication errors.

In some groups, members openly acknowledged and discussed their medication errors and ways they could avoid them happening. In others, members kept information about errors to themselves. Learning about the causes of these errors, as a team, and devising innovations to prevent future errors were only possible in groups where there was psychological safety and nurses felt safe to speak up.

Constructive controversy

Hearing all voices inevitably means creating the potential for conflict because of differing perspectives and interests. The skill to effectively manage competing perspectives is fundamental to inclusion, which in turn generates creativity and innovation (Tjosvold 1998, Nemeth and Owens 1996, Mumford and Gustafson 1988). In inclusive teams, where all voices are heard, team members are more committed to performing their work effectively than to bland consensus or personal victory in conflict.

In a co-operative team, constructive controversy improves quality of decision-making and creativity (Tjosvold 1998 and 1982, Tjosvold et al 1986, Tjosvold and Field 1983, Tjosvold and Johnson 1977). It involves fully exploring opposing opinions and analysing task-related issues. It can take place in situations where people:

- believe they are in a co-operative group that emphasises shared goals and their voices are heard and valued, rather than in a competitive context
- feel their personal competence is confirmed, rather than questioned, when they speak up
- perceive processes of mutual influence rather than attempted dominance.

Positive climates of inclusion

When staff work in a climate of inclusion and feel their voices are listened to and acted on, they are more positive, committed and satisfied at work (Dixon-Woods et al 2013). This has a significant impact on willingness to adapt to and initiate change. In turn, positive moods are associated with:

- increased compassion, pro-social or helping behaviours (see Michie 2009, Lee and Allen 2002, George 1995)
- higher levels of creativity (Amabile et al 2005)
- increased innovation (Shipton et al 2006)
- higher job satisfaction, motivation and productivity (Dries and Pepermans 2007, Martin 2005, Fisher and Ashkanasy 2000, Staw et al 1994)
- effective decision-making and conflict resolution (see Isen and Baron 1991).

Disagreeing with the majority – minority dissent

Minority influence theory offers another important perspective on inclusion and creativity. Those disagreeing with the majority view (minority voices) stimulate innovation and improve decision-making (Maass and Clark 1984). Where minority dissent is suppressed, there are low levels of creativity, innovation, individuality and independence (De Dreu and De Vries 1993, see also Nemeth and Staw 1989).

Disagreement about ideas within a group ('voice') is beneficial since it can improve decision-making and strategic planning (Schweiger et al 1989, Cosier and Rose 1977, Mitroff et al 1977). So a key theme in research on innovation is the importance of integrating diverse perspectives by encouraging all to voice their views and participate in decision-making by contributing their knowledge, skills and experience to the innovation process.

Diversity

Van Knippenburg and Schippers (2007) showed that greater diversity of voices offers more information, which in turn improves problem-solving, quality of decisions, creativity and innovation. However, at the same time, diversity leads to intergroup bias, with team members having less liking for, trust in, and co-operation with others who are dissimilar to themselves. So from this perspective, diversity can be seen as disrupting performance.

To manage this tension, leaders need to value diversity of views and voices while, at the same time, building a strong and proud identity for their teams and for the organisation. In particular, leaders can increase the benefits of voice and diversity while reducing the disadvantages, by encouraging everyone

to appreciate the benefits of diversity for team and organisational functioning ('diversity beliefs).

Van Knippenburg and colleagues have shown that when team members believe in the value of diversity, diversity has positive effects on team processes and team performance (van Knippenberg et al 2007).

Patient/service user voice

Research on organisations' competencies has shown the importance of effective engagement with service users in identifying opportunities for innovation and improvement. Drucker (1985) argues that this should include reflection on:

- customers' unexpectedly positive or negative responses to services
- incongruities between actual and perceived customer expectations
- incongruities between industry and customers' attitudes towards quality
- changes in demographic and social trends, including changes in customers' mood and perceptions in relation to the organisation's products or services.

In healthcare, researchers have highlighted the opportunities for improvement and innovation that come from greater attention to and understanding of patients' preferences. This can avoid costly and inappropriate treatment (Mulley et al 2012). Christensen emphasises the importance of deep reflection on the 'customer's' needs as a mechanism for identifying opportunities for radical innovation. Organisations need to see their roles as meeting patients'/service users' needs rather than seeing themselves as delivering particular 'services'. They also need to research more deeply which needs patients and communities want to address when seeking healthcare (Christensen 1997).

Reflexivity and 'after action' reviews

Healthcare organisations are pressured environments and often feel frenetic. Extensive research shows that when team members take time out from this 'busy-ness' to listen to each other, review and reflect, they are much more effective – both in terms of productivity and innovation (Schippers et al 2012). A variety of studies has shown links between reflexivity and team innovation and effectiveness in healthcare and other sectors (Borrill et al 2000, Carter and West 1999, Curtin et al 2010, Widmer et al 2009). There is also evidence that healthcare teams with high levels of demands – but which take time out more regularly than others to reflect, plan and act – introduce many more innovations in their work than teams that are less reflexive (Schippers et al 2014, 2015).

In related research, a meta-analysis of 49 samples revealed that, on average, debriefs or after-action reviews improve effectiveness by on average 25% (Tannembaum and Cerasoli 2013). The value of these reviews as a way of hearing the voices of all team members is consistently demonstrated in healthcare environments.

How is it done?

Listening with fascination and inclusion are core cultural characteristics of organisations that deliver high quality, continually improving and compassionate care. This approach should ensure there are mechanisms and processes to make sure everyone's voice is heard, empowered and acted on.

This includes the voices of patients and carers, but also staff – especially those from groups often discriminated against. It also includes staff witnessing errors that could harm patients or staff, and whistleblowers.

Whistleblowers' voices are often not heard when they speak with anger and frustration, as this can result in senior leaders tending to mute the message (Wellman et al 2016). Being aware of this typical reaction may help leaders listen more effectively to those with important messages about organisational performance.

Listening to and including diverse voices is enabled by five important and mutually reinforcing processes:

- interaction – making sure relevant individuals or groups meet sufficiently frequently to exchange information
- information-sharing – ensuring that information-sharing is a two-way process
- influence over decision-making – ensuring that inclusion and listening lead to influence over decisions rather than empty processes
- genuine participation – as opposed to token consultation
- developing psychological safety – compassionate leadership at every level of the organisation.

The following pages provide practical tips on:

- creating a climate for inclusion
- creating constructive controversy
- valuing diversity
- patient/service user involvement
- reflexivity and reviewing.

Practical tips

Creating a climate for inclusion

- developing a positive climate characterised by positive moods and emotions
- high levels of humour, warmth and optimism, recognition and appreciation
- low levels of aggressive, intimidating, bullying, discriminatory or harassing behaviour
- a learning orientation about near misses and errors: 'What can we learn from this?'
- positive team affect and constructive management of conflict
- high levels of employee engagement in every part of the organisation
- high levels of perceived justice

Creating constructive controversy

- members of all teams commit to performing their work effectively and excellently
- team members not seeking bland consensus or personal victory in conflict
- full exploration of opposing opinions and frank analyses of task-related issues in teams
- team members work in a co-operative group, rather than competitively
- team members feel their personal competence is confirmed in teams
- team members mutually influence rather than attempt dominance
- team members see the acceptance of constructive conflict within the team with an open atmosphere
- voice and dissent are encouraged

Valuing diversity

- diversity in experience and backgrounds at all levels in the organisation
- diversity of experience and perspectives within the senior management team
- diversity of perspective and background is positively valued by all

Patient/service user involvement

- genuine patient and carer involvement in governance and strategy
- deep understanding of, and reflection on, patient needs across the organisation
- effective methods for authentically engaging patients in service redesign, governance and innovation

Reflexivity and reviewing

- teams and individuals take time out regularly to review objectives
- teams and individuals take time out regularly to review performance and work processes and how these can be improved
- teams, shifts, departments conduct regular 'after-action' reviews to determine what performance was expected, what variations there were in performance, what went well and not well, and what can be learned and changed
- shifts, surgeries and other action-team events have regular after-action reviews, with data collation to enable team learning

Dixon-Woods et al (2013) showed that organisations must be especially alert to the possibility of blind spots where they are unaware of problems. It is important to:

- generate intelligence through multiple strategies
- carry out self-assessment of local culture and behaviours, not just relying on mandated measures
- use a range of techniques for hearing the patient's voice and the voice and insights of those at the sharp end of care.

Staff experience frustration and conflict when they are asked to work in systems that serve neither them, nor the patients they care for, effectively. Dixon-Woods et al's work suggests that improving culture, behaviour and systems requires not only systems improvement but also better communication between senior leadership and frontline staff. This needs to be sustained, intense, mutually respectful, and focused on achieving a shared understanding of quality problems and joint working to put them right.

References

Amabile TM, Barsade SG, Mueller JS, Staw BM (2005) Affect and creativity at work *Administrative Science Quarterly* 50 (3): 7–403

Borrill C, West MA, Shapiro D, Rees A (2000) Team working and effectiveness in health care. *British Journal of Health Care* 6 (8): 364–71

Carter AJ West MA (1999) Sharing the burden – teamwork in health care settings. In Firth-Cozens J, Payne R (eds) Stress in health professionals. John Wiley & Sons, Chichester: 191–202

Christensen CM (1997) The innovator's dilemma. Harvard Business School, Cambridge, MA

Cosier RA, Rose GL (1977) Cognitive conflict and goal conflict effects on task performance. *Organizational Behavior and Human Performance* 19 (2): 378–391

Curtin SM, Flood P, Ramamoorthy N, West MA, Dawson JF (2010) The top management team, reflexivity, knowledge sharing and new product performance: a study of the Irish software industry. *Creativity and Innovation Management* 19 (3): 219–232

De Dreu CK, De Vries NK (1993) Numerical support, information processing and attitude change. *European Journal of Social Psychology* 23 (6): 647–662

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, Willars J (2013) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *Quality and Safety in Health Care* 23: 106–115

Dries N, Pepermans R (2007) 'Real' high-potential careers: an empirical study into the perspectives of organisations and high potentials. *Personnel Review* 37 (1): 85–108

Drucker PF (1985) Innovation and entrepreneurship practices and principles. AMACON, New York

Edmondson AC (1996) Learning from mistakes is easier said than done: group and organizational influences on the detection and correction of human error. *The Journal of Applied Behavioral Science* 32 (1): 5–8

Edmondson A (1999) Psychological safety and learning behavior in work teams. *Administrative Science Quarterly* 44 (2): 350–383

Fisher CD, Ashkanasy NM (2000) The emerging role of emotions in work life: an introduction. *Journal of Organizational Behavior* 21: 123–129

George, JM (1995) Leader positive mood and group performance: The case of customer service *Journal of Applied Social Psychology* 25: 778–794

Isen AM, Baron RA (1991) Positive affect as a factor in organisational-behavior *Research in Organizational Behavior* 13: 1–53

Lee K, Allen NJ (2002) Organizational citizenship behavior and workplace deviance: the role of affect and cognitions. *Journal of Applied Psychology* 87 (1): 131

Maass A, Clark RD (1984) Hidden impact of minorities: fifteen years of minority influence research. *Psychological Bulletin* 95 (3): 428

Martin AJ (2005) The role of positive psychology in enhancing satisfaction, motivation, and productivity in the workplace. *Journal of Organizational Behavior Management* 24 (1–2): 113–133

Michie S (2009) Pride and gratitude: how positive emotions influence the prosocial behaviors of organizational leaders. *Journal of Leadership and Organizational Studies* 15: 393–403

Mitroff II, Barabba VP, Kilmann RH (1977) The application of behavioral and philosophical technologies to strategic planning: a case study of a large federal agency *Management Science* 24 (1): 44–58

Mulley AG, Trimble C, Elwyn G (2012) Patients' preferences matter: stop the silent misdiagnosis. The King's Fund, London Available at: http://www.bmj.com/content/345/bmj.e6572

Mumford MD, Gustafson SB (1988) Creativity syndrome: integration, application, and innovation *Psychological Bulletin* 103 (1): 27

Nemeth C, Owens P (1996) Making work groups more effective: the value of minority dissent. In West MA (ed) Handbook of work group psychology. John Wiley, Chichester: 125–142

Nemeth CJ, Staw BM (1989) The tradeoffs of social control and innovation in groups and organizations. *Advances in Experimental Social Psychology* 22: 175–210

Schippers MC, West MA, Dawson JF (2015) Team reflexivity and innovation: the moderating role of team context. *Journal of Management* 41 (3): 769–788

Schippers MC, Edmondson AC, West MA (2014) Team reflexivity as an antidote to team information-processing failures. *Small Group Research* 45 (6): 731–769

Schweiger DM, Sandberg WR, Rechner PL (1989) Experiential effects of dialectical inquiry, devil's advocacy and consensus approaches to strategic decision making. *Academy of Management Journal* 32 (4): 745–772

Shipton H, West MA, Dawson J, Birdi K, Patterson M (2006) HRM as a predictor of innovation. *Human Resource Management Journal* 16 (1): 3–27

Staw BM, Sutton RI, Pelled LH (1994) Employee positive emotion and favorable outcomes at the workplace. *Organization Science* 5 (1): 51–71

Tannenbaum SI, Cerasoli CP (2013) Do team and individual debriefs enhance performance? A meta-analysis. *Human Factors* 55 (1): 231–245

Tjosvold D (1998) Cooperative and competitive goal approach to conflict: accomplishments and challenges *Applied Psychology* 47 (3): 285–313

Tjosvold D, Wedley WC, Field RH (1986) Constructive controversy, the Vroom Yetton model, and managerial decision making *Journal of Organizational Behavior* 7 (2): 125–138

Tjosvold D, Field RH (1983) Effects of social context on consensus and majority vote decision making. *Academy of Management Journal* 26 (3): 500–506

Tjosvold D (1982) Effects of approach to controversy on superiors' incorporation of subordinates' information in decision making. *Journal of Applied Psychology* 67 (2): 189–93

Tjosvold D, Johnson DW (1977) Effects of controversy on cognitive perspective taking. *Journal of Educational Psychology* 69 (6): 679

Van Knippenberg D, Schippers MC (2007) Work group diversity. *Annual Review of Psychology* 58: 515–541

Van Knippenberg D, Haslam SA, Platow MJ (2007) Unity through diversity: value-in-diversity beliefs, work group diversity, and group identification *Group Dynamics: Theory, Research, and Practice* 11 (3): 207

Wellman N, Mayer DM, Ong M, DeRue DS (2016) When are do-gooders treated badly? Legitimate power, role expectations, and reactions to moral objection in organizations *Journal of Applied Psychology* 101 (6): 793

West M, Dawson J, Kaur M (2012) Employee engagement and NHS performance. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

West M, Dawson J, Kaur M (2015) Making the difference: diversity and inclusion in the NHS. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

West MA, Chowla R (2017) Compassionate leadership for compassionate healthcare. In Gilbert P (ed) Compassion: concepts, research and applications Routledge, London: 237–257

Worline MC, Dutton JE, (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler, Oakland CA

Widmer PS, Schippers MC, West MA (2009) Recent developments in reflexivity research: a review. *Psychology of Everyday Activity* 2 (2): 2–11

Further reading

The best medicine: 100 powerful stories of staff-led change from the NHS

This guide presents stories from organisations using 'Listening into action' to 'shake things up' and put staff at the centre of change. 'Listening into action' creates a new language around change, aligning leaders behind the need for a fundamental shift and joining forces to unblock the way for staff.

View or download at www.listeningintoaction.co.uk

LIA is owned by Optimise Limited. Contact: Hannah Forbes at hforbes@optimiselimited.co.uk

Coaching

A collaborative approach to learning and development empowers people to set their own goals and explore their own solutions to problems.

What is it?

Coaching is a collaborative relationship between a coach and the person receiving coaching, designed to support the person to attain their professional or personal goals (Grant et al 2010). Organisations use it to enhance and manage performance. It is suitable for managers and non-managers.

Coaching is intended to help people reflect on, explore and clarify problems, set objectives and review performance. It can also help them learn new skills, handle difficult problems, manage conflicts or learn to work effectively across boundaries.

Why is it important?

- Coaching can provide many benefits, particularly in providing support and feedback for individuals during times of change, transition, professional development and challenge and for those with strategic responsibilities (Spence et al 2006).
- Coaching is seen as a valuable intervention for leaders in the NHS who are required to demonstrate learning agility and flexibility in a dynamic environment.
- Coaching is a helpful skill that NHS leaders can use themselves to develop and empower the people who report to them or colleagues.
- Coaching can help managers make sense of challenging situations and conflicts and deal with them effectively.

Peer coaching

Peer coaching is a distinct type of coaching that brings together people of similar experiences, status and expertise. Its features are (Schwellnus and Carnahan 2014):

- a voluntary relationship that is collaborative and non-competitive
- a self-evaluative component
- coach feedback
- goal/preferred outcome-setting
- focus on strengths and positive inquiry.

Benefits include discussing issues using familiar language and the non-threatening/non-competitive climate it creates (Ladyshewsky 2010).

What is the evidence?

There has been limited research examining the effectiveness of coaching, but what there is has been favourable (De Haan et al 2013):

- Hall et al (1999) reported a study of 75 people from six companies for whom executive coaching was helpful.
- Olivero et al (1997) assessed outcomes associated with a three-day training workshop, augmented by eight weeks of executive coaching focused on individual action projects. The results suggested the managers were more productive as a result of the training and these effects were augmented by the

coaching. Indeed, coaching had the stronger effects of the two interventions.

- In a small sample of teachers, Grant et al (2010) showed improvement in goal attainment, resilience and wellbeing, and reduced stress for teachers receiving coaching, compared to no change over the same period for a control group.
- Bowles et al (2007) produced similarly positive results.

A careful review suggests coaching has clear benefits, but more solid evidence is needed to demonstrate effectiveness in predicting team and organisational performance outcomes. Much depends on the quality of coach training, clarity of structure and processes of coaching, the underlying theoretical model, supervision of coaches and clarity about the overall purpose.

Peer coaching

Schwellnus and Carnahan (2014) synthesised a large body of research to define peer coaching and explore the evidence to support its use in healthcare settings. The findings were largely positive, though based on self-reported data.

How does it work?

Unlike formal training courses, coaching is usually a one-to-one relationship tailored to individual employees. Ideally it comprises a compassionate, safe, trusting relationship between coach and coachee. It should (CIPD 2017):

- be non-directive with a focus on improvement
- emphasise issues at work
- integrate organisational and individual goals
- give feedback on strengths and weaknesses.

Coaching can also involve instruction or facilitation – for example:

- instruction focused on improving performance and skills through tutoring (Parsloe 1995)
- facilitation versus directing performance, guiding learning and development (Downey 1999).

The coaching sessions may focus on skills, performance or competencies:

- skills coaching – designed to help people learn and apply particular skills at work
- performance coaching – designed to focus on goal setting and performance delivery over time
- developmental coaching – a more widely strategic approach that aims to help people develop competencies and capabilities to deal with current and future demands.

Organisations may use coaching in other ways, such as to address poor performance issues:

- when an individual's performance declines
- for leadership development, providing a 'safe' person to discuss organisational challenges with
- to boost an individual's confidence following long-term absence from work
- to help with a personal issue that is affecting work.

Mentoring

A related developmental intervention is mentoring. While coaching is concerned with improving specific aspects of performance, mentoring involves providing generalised support and guidance to an individual within the organisation, usually by a senior colleague but sometimes by a senior, experienced person outside the organisation.

Although the two approaches share some techniques, such as inquiry, clarification and reframing, they have distinct differences. Coaching tends to be shorter-term and for a defined period, while mentoring can be a much longer-term intervention. Someone moving from one role to another may be given a role-equivalent mentor who may support them as they grow into their new role.

Tips

In well-developed coaching systems, organisations are committed to (Clutterbuck and Megginson 2006):

- creating a culture and coaching procedures that are aligned with the philosophy of coaching
- building coaching responsibilities into people's jobs and providing appropriate time and recognition for this contribution
- assessing coaches' skills and ensuring they have appropriate training and supervision as well as opportunities for upgrading their skills
- selecting for coaching roles staff who have positive attitudes, emotional sensitivity and commitment to the role
- monitoring the effectiveness of coaching and its impact within the organisation, and adapting the system as appropriate.

The relationship between the coach and the person receiving coaching is particularly important. A strong and positive coaching relationship correlates significantly with the outcomes as rated by the person receiving coaching.

References

Bowles SV, Cunningham CJL, De La Rosa GM, Picano JJ (2007) Coaching leaders in middle and executive management: goals, performance, buy-in. *Leadership and Organization Development Journal* 28: 388–408

Chartered Institute of Personnel and Development (2017) Coaching and mentoring. Factsheet. CIPD, London. Available at: www.cipd.co.uk/knowledge/fundamentals/people/development/coaching-mentoring-factsheet (accessed 6 March 2017)

de Haan E, Duckworth A, Birch D, Jones C (2013) Executive coaching outcome research: the contribution of common factors such as relationship, personality match, and self-efficacy. *Consulting Psychology Journal: Practice and Research* 65 (1): 40

Downey M (1999) Effective coaching. Orion Business Books, London

Garrett-Harris R, Garvey B (2005) Towards a framework for mentoring in the NHS. Sheffield Hallam University, Sheffield

Grant AM, Passmore J, Cavanagh MJ, Parker HM (2010) The State of Play in Coaching Today: A Comprehensive Review of the Field. *International Review of Industrial and Organizational Psychology* 25 (1): 125–167

Hall DT, Otazo KL, Hollenbeck GP (1999). Behind closed doors: what really happens in executive coaching. *Organizational Dynamics* 27 (3): 39–53

Ladyshewsky RK (2010) The manager as coach as a driver of organizational development. *Leadership and Organization Development Journal* 31 (4): 292–306

Olivero G, Bane KD, Kopelman RE (1997) Executive coaching as a transfer of training tool: effects on productivity in a public agency. *Public Personnel Management* 26: 461–469

Parsloe E (1995) Coaching, mentoring and assessing: a practical guide to developing competence. Kogan Page, New York

Schwellnus H, Carnahan H (2014) Peer-coaching with health care professionals: What is the current status of the literature and what are the key components necessary in peer-coaching? A scoping review. *Medical Teacher* 36 (1): 38–46

Spence GB, Cavanagh MJ, Grant AM (2006) Duty of care in an unregulated industry: initial findings on the diversity and practices of Australian coaches. *International Coaching Psychology Review* 1 (1): 71–85

Steven A, Oxley J, Fleming WG (2008) Mentoring for NHS doctors: perceived benefits across the personal–professional interface. *Journal of the Royal Society of Medicine* 101 (11): 552–557

Mentoring

A mentoring partnership can help staff clarify their aspirations and goals and develop skills while benefiting from a supportive, reassuring relationship.

What is it?

Mentoring involves a committed long-term relationship between an experienced (usually senior) leader in an organisation and a more junior or less experienced individual. The mentor provides:

- career support such as sponsorship, job assignments, coaching and high visibility for the individual to help them move in the direction of their career aspirations
- social support including advice, encouragement and compassion to ensure the individual receives emotional support as well as practical guidance and advice
- a role model acting as an example of (hopefully) wise and compassionate leadership. It is closely related to coaching.

The relationship is also beneficial for the mentor. Where the mentor is a leader or manager, they see improved performance in those they manage, their teams and their work units. Staff will have improved motivation. Mentoring is a more satisfying and easier way to manage and lead than command-and-control approaches, particularly in healthcare.

Why is it important?

Mentors help leaders and potential leaders by offering acceptance, encouragement, counselling, sponsorship, protection, challenging assignments, exposure and visibility. This results in learning and support for individuals, with far more effective leadership development than would otherwise be the case. Mentoring can facilitate adjustment, learning and stress reduction during difficult job transitions. It can also contribute to greater organisational commitment and lower turnover among leaders and potential leaders.

Mentoring benefits mentors themselves by building relationships and a sense of service within the organisation. It is therefore a powerful way to support potential and existing leaders beyond simply providing training courses.

What is the evidence?

The research evidence is clear in suggesting that mentoring is associated with better performance, more recognition, increased pay, better career opportunities and more promotions (McCauley and Hezlett 2001).

Mentoring appears to result in more career advancement and success for the protégé (Chao et al 1992, Turban and Dougherty 1994, Wilson 2008) and higher levels of organisational commitment (Payne and Huffman 2005).

Identity matching – pairing people with similar backgrounds – is important too. Avery et al (2008) showed that matching gender and attitudes resulted in more career development and emotional support for the person being mentored. Similarly, Koberg et al (1998) found that matching people on the basis of sex and race improved the quality of mentoring (see also Scanduara and Williams 2001). The higher the status of the mentor, the better (Ragins 2007).

NHS mentoring schemes

There are several NHS mentoring schemes, for clinicians and non-clinicians alike. One study, looking at six clinical mentoring schemes, found consistently positive outcomes in terms of perceived benefits self-reported by mentees and mentors (Steven et al 2008).

Garrett-Harris and Garvey (2005) evaluated mentoring in the NHS to produce a standardised framework. Its key points are:

- Mentoring benefits for employees include skill development, cross-cultural working and diversity, improved confidence, career choice and development, increased self-awareness.
- Wider-system/external support is critical.
- Mentoring must be linked to strategic aims.
- Collective engagement (across the organisational levels) is important.
- Evaluation should be built into any mentoring scheme.
- Mentor/mentee matching is key to ensure good rapport.
- Training and support are needed for mentors and mentees.

For more detail on this report, including case studies of best practice, go to:

http://scottishmentoringnetwork.co.uk/assets/downloads/resources/Towards-Framework-Mentoring-NHS.pdf

How is it done?

Essentially, mentoring involves two people meeting to discuss the mentee's working life. Some organisations run formal mentoring schemes that pair junior and senior employees, creating a structure for their interactions over a specified period.

Managers as mentors

In some organisations, managers are expected to coach and mentor everyone they lead. This means all managers must be trained in mentoring and coaching skills. There are several benefits to this approach. For example:

- coaching is available to a wider range of staff, rather than just a select few
- because managers generally have frequent interactions with those they manage, there are many opportunities for helpful mentoring and coaching conversations
- because managers already have a detailed understanding of the work of their staff, the mentoring and coaching conversations can be tailored to the practical needs of those they lead.

Encouraging managers in the NHS to adopt mentoring rather than directive styles with those they manage is consistent with the emphasis on compassionate leadership in the culture and leadership work.

Mentoring and compassionate leadership

Compassionate leadership and mentoring go hand in hand. Compassionate leadership has four components, all entirely consistent with mentoring orientations:

- attending – paying close attention to the mentee and what they say
- understanding – making sure the mentee feels the mentor is listening to their concerns and understands the situations they face
- empathising – mirroring emotion, enabling the mentor to arrive at a deeper understanding of the other's situation
- helping – taking thoughtful and intelligent action to help the mentee.

For a full explanation of each of these components, go to Compassionate leadership.

Tip: Key ingredients for successful mentoring programmes

Organisational support for the programme

- Senior management and board involvement and support
- Training for managers in coaching and mentoring skills, clear communications about the purpose, scope and value of the programme
- Alignment with organisational vision and values

Clarity of purpose, expectations and roles

- A focus on enhancing leadership development in-house and reinforcing core leadership values (such as compassion)
- Frequency of meetings, time expectations and duration of the relationship
- The functions of providing practical support, social support and role modelling
- The importance of the mentee committing to the relationship
- Absolute confidentiality in relation to sensitive conversations

Participant choice and involvement

- Ensuring the whole process is voluntary rather than imposed, for mentors and mentees alike

Careful selection and matching procedures

- Careful consideration of how those involved are selected, and aligning this with the organisation's talent management and leadership development approaches
- Seeking to involve all or most aspiring or existing leaders who would like to be involved, to ensure the programme's maximum impact in supporting the organisation's leadership development strategy

Continuous monitoring and evaluation

- The processes must be monitored and evaluated to determine the effectiveness and benefits for mentors and mentees alike
- Regularly evaluating managers' knowledge, skills and abilities as mentors, and appraising and assessing them in relation to how well they ensure the development of those they lead

Promoting equality and diversity

- Making sure mentoring support is proactively provided to minority groups or groups discriminated against to correct the gross imbalance of leadership and job enrichment opportunities currently available to them

Sources: Parsloe (1995), Steven et al (2008)

References

Avery DR, Tonidandel S, Phillips MG (2008) Similarity on sports sidelines: how mentor–protégé sex similarity affects mentoring. Sex Roles 58 (1–2): 72–80

Chao GT, Walz P, Gardner PD (1992) Formal and informal mentorships: a comparison on mentoring functions and contrast with nonmentored counterparts. *Personnel Psychology* 45 (3): 619–636

Garrett-Harris R, Garvey B (2005). Towards a framework for mentoring in the NHS. Sheffield Hallam University, Sheffield

Koberg CS, Boss RW, Goodman E (1998) Factors and outcomes associated with mentoring among health-care professionals. *Journal of Vocational Behavior* 53 (1): 58–72

McCauley CD, Hezlett SA (2001) Individual development in the workplace. *Handbook of Industrial, Work, and Organizational Psychology* 1: 313–335

Payne SC, Huffman AH (2005) A longitudinal examination of the influence of mentoring on organizational commitment and turnover. *Academy of Management Journal* 48 (1): 158–168

Parsloe E (1995) Coaching, mentoring and assessing: a practical guide to developing competence. Kogan Page, New York

Ragins BR (2007) Diversity and workplace mentoring relationships: a review and positive social capital approach. Eby LT (ed) The Blackwell handbook of mentoring: a multiple perspectives approach. Blackwell, Oxford: 281–300

Scandura TA, Williams EA (2001) An investigation of the moderating effects of gender on the relationships between mentorship initiation and protégé perceptions of mentoring functions. *Journal of Vocational Behavior* 59 (3): 342–363

Steven A, Oxley J, Fleming WG (2008) Mentoring for NHS doctors: perceived benefits across the personal–professional interface. *Journal of the Royal Society of Medicine* 101 (11): 552–557

Turban DB, Dougherty TW (1994) Role of protégé personality in receipt of mentoring and career success. *Academy of Management Journal* 37 (3): 688–702

Wilson M (2008) Developing future leaders for high-growth Indian companies. Center for Creative Leadership, Greensboro, NC

Inclusive leadership development

Prioritising under-represented or minority groups in leadership development plans is important for redressing the inequalities across healthcare and society.

What is it?

If an organisation wants a culture of inclusion, appreciation and care, it is important that it runs a talent development programme focused on minorities (Coghill 2013). This ensures participants and organisations can realise the full value of development initiatives and all groups are properly included.

Why is it important?

Leadership development has to be inclusive, to ensure opportunity is not denied to staff simply because of their demographic characteristics.

The NHS's culture needs to be sustained by the core values in the NHS Constitution, including respect and dignity, compassion and inclusion. These values have particular resonance given the diversity of the NHS workforce (West et al 2015).

However, despite many calls to address the diversity gaps across the NHS workforce, progress is slow (Kline 2014). Among staff, there is poorer representation of black and minority ethnic (BME) groups, women, lesbian, gay, bisexual and transgender (LGBT) people, people with disabilities and certain religious groups in senior positions (West et al 2015). And at all levels, people from these groups experience more discrimination (West et al 2015).

The National Improvement and Leadership Development Framework, Developing People – Improving Care (NILD Board 2016), emphasises the importance of valuing difference and nurturing inclusivity. Organisations striving to align with this framework value diversity and actively nurture inclusive cultures.

Find out more at https://improvement.nhs.uk/resources/developing-people-improving-care/

Find out more

If you are interested in diversity in the context of the NHS, it is important you read: Diversity, Identity-based talent management, Inclusion: listening to all voices and Diversity and equal opportunities training.

What is the evidence?

An employee's demographic characteristics will have a major impact on their opportunities for challenge, leadership development and career progression (Douglas 2003). Staff who are female, or from BME or lower socio-economic groups are likely to be told they need more development, while receiving fewer opportunities for it (Munusamy et al 2010).

Better workforce representation leads to clear benefits for the organisation and its service users/patients (Hunt et al 2015). It is essential that leaders of organisations in the NHS quickly reflect the demography of the patient population they serve to minimise health inequalities. This is vital not only for moral reasons, but because there is evidence that diversity benefits organisational outcomes in the NHS (King et al 2011, West et al 2011).

How does it work?

In a multicultural workplace, creating an inclusive culture that celebrates diversity and difference requires a good understanding of the complex nature of social identity at work before development programmes can be designed (Munusamy et al 2010).

So organisations need to take specific care to ensure the leadership development of under-represented groups. And placing social identity at the heart of the design process is vital for ensuring the programme content meets participants' needs (Guillen et al 2015, Hewlett et al 2005, Lord and Hall 2005, Munusamy et al 2010).

Programme designers must consider not only the types of social identities they are reinforcing, but those they are excluding. When Van Velsor and Hughes-James (1990) explored gender differences in learning outcomes after a given learning opportunity, they found the men learned much more than the women. This does not indicate that women are less able to learn: it shows that the content was not designed with women or mixed-gender participants in mind.

Debate continues about whether this approach is the answer. The evidence is not yet supportive (Bezrukova et al 2014). But such programmes offer a psychologically safe space for sharing and consoling. They enable members to easily relate to one another and see that their leadership challenges linked to their shared social identities are common among other participants. They also open up an opportunity for reconciling multiple, seemingly contradictory elements of one's identity such as 'how can I be a woman and a leader?' and for identifying possible role models (see also Douglas 2003, Livers and Caver 2003 and 2004, Munusamy et al 2010, Vinnicombe and Singh 2002a and 2002b, Peters et al 2012).

If an employee strongly identifies with a demographic group that is under-represented in their organisation, they may benefit from a programme tailored to that group's specific needs.

Single-identity programmes

To address this issue of 'no one size fits all', single-identity programmes including BME-specific programmes and women-only leadership development have emerged (such as The King's Fund's Athena programme).

Debate continues about whether this approach is the answer. The evidence is not yet supportive (Bezrukova et al 2014). But such programmes offer a psychologically safe space for sharing and consoling. They enable members to easily relate to one another and see that their leadership challenges linked to their shared social identities are common among other participants. They also open up an opportunity for reconciling multiple, seemingly contradictory elements of one's identity such as 'how can I be a woman and a leader?' and for identifying possible role models (see also Douglas 2003, Livers and Caver 2003 and 2004, Munusamy et al 2010, Vinnicombe and Singh 2002a and 2002b, Peters et al 2012).

However, it is important that inclusion and acceptance of difference are consistently modelled outside leadership development programmes too, ensuring the right conditions exist for leaders from under-represented groups to apply their knowledge and grow (Thomas and Ely 1996).

For this reason, the distribution of opportunities should positively discriminate in the direction of those from under-represented groups (Equality Act 2010) www.gov.uk/guidance/equality-act-2010-guidance

Following the theory of critical mass (Konrad et al 2008), it is important that programmes for leaders from these groups are not tokenistic. By making a point of frequently offering leadership development opportunities to members of under-represented groups, you can begin to create a culture where promoting difference becomes 'the way things are done around here' (West et al 2015).

At the same time, it is important to make visible efforts to embed these programmes in to overall talent development approaches and create positive examples, role models and success cases of under-represented leaders across the organisation.

Policies and procedures

Effective diversity management policies, practices and procedures are vital. They can shape and reinforce equal employment via approaches to (among other things):

- selection and promotion policies – setting hard, challenging but realistic goals to select and promote ever-greater numbers of demographically under-represented leaders
- coaching and mentoring of under-represented groups
- mobility policies and the use of quotas to influence selection and promotion decisions
- job security including, for example, providing additional conditions for employees from protected classes
- appraisal processes, disciplinary procedures and rewards systems
- job design, including workplace accessibility
- methods for encouraging staff participation in decision-making, information-sharing, dialogue and interaction throughout organisations.

Research suggests it is particularly important to have visible and sustained senior-management support for positive diversity and inclusion policies and practices (Munusamy et al 2010, Thomas and Ely 1996, Van Velsor et al 2010). But it is equally important that these are seen to be implemented effectively and are consistently reinforced by middle management and frontline supervisors.

Tips

- Set clear, challenging goals to ensure leadership development opportunities achieve the aims of representative leadership within three-to-five years.
- Review leadership development strategy annually to ensure it meets the needs of under-represented groups.
- Make sure all other HR and organisational development approaches reinforce and complement leadership development focused on under-represented groups.
- Encourage all leaders to take responsibility for coaching and mentoring staff from under-represented groups to enable them to achieve their potential and ensure representativeness across the organisation.
- Diversity management strategies and programmes seeking to increase leadership diversity need to frame equality, diversity and inclusion efforts as being in the interests of creating a positive learning and development climate for all in the organisation.

References

Bezrukova K, Spell CS, Perry JL, Jehn KA (2016) A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin* 11: 1227–1274

Coghill Y (2013) Grasp the nettle of inequality. *HSJ* 28 November. Available at: www.hsj.co.uk/comment/grasp-the-nettle-of-inequality/5065670.article (accessed on 1 August 2017)

Douglas CA (2003) Key events and lessons for managers in a diverse workforce: a report on research and findings. Center for Creative Leadership, Greensboro, NC

Guillen L, Korotov K, Mayo M (2015) Is leadership a part of me? An identity approach to understanding the motivation to lead. *Leadership Quarterly* 26 (5): 802–820

Hewlett SA, Luce CB, West C (2005) Leadership in your midst: tapping the hidden strengths of minority executives. *Harvard Business Review* 83 (11): 74–82

Hunt V, Layton D, Prince S (2015) Diversity matters. McKinsey and Company, New York

King EB, Dawson JF, West MA, Gilrane VL, Peddie CI, Bastin L (2011). Why organizational and community diversity matter: representativeness and the emergence of incivility and organizational performance. *Academy of Management Journal* 54 (6): 1103–1118

Kline R (2014) The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Middlesex University, London

Konrad AM, Kramer V, Erkut S (2008) Critical mass: the impact of three or more women on corporate boards. *Organizational Dynamics* 37 (2): 145–164

Livers AB, Caver KA (2003) Leading in black and white: working across the racial divide in corporate America (vol 26). Jossey Bass/Center for Creative Leadership, San Francisco, CA

Livers AB, Caver KA (2004) Leader development across race. In McCauley CD, van Velsor E (eds) Handbook of leadership development. Chapter 2. Jossey Bass, San Francisco, CA: 304–330

Lord RG, Hall RJ (2005) Identity, deep structure and the development of leadership skill. *Leadership Quarterly* 16 (4): 591–615

Munusamy VP, Ruderman MN, Eckert RH (2010) Leader development and social identity. The Center for Creative Leadership handbook of leadership development (3rd edition) Jossey-Bass, San Francisco, CA: 147–175

NILD Board (2016). *Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services*. London: NHS Improvement.

Peters K, Ryan M, Haslam SA, Fernandes H (2012) To belong or not to belong. *Journal of Personnel Psychology* 11 (3): 148–158

Thomas DA, Ely RJ (1996) Making differences matter. *Harvard Business Review* 74 (5): 79–90

Van Velsor E, McCauley CD, Ruderman MN (eds) (2010) The Center for Creative Leadership handbook of leadership development. Jossey Bass, San Francisco, CA

Van Velsor E, Hughes-James M (1990) Gender differences in the development of managers: how women managers learn from experience. Center for Creative Leadership, Greensboro, NC

Vinnicombe S, Singh V (2002a) Sex role stereotyping and requisites of successful top managers. *Women in Management Review* 17 (3/4): 120–130

Vinnicombe S, Singh V (2002b) Women-only management training: an essential part of women's leadership development. *Journal of Change Management* 3 (4): 294–306

West MA, Dawson JF, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 28 July 2017)

West M, Dawson J, Kaur M (2015) Making the difference: diversity and inclusion in the NHS. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

Other useful material

www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/

Programme – 'Stepping Up'
www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme/

Health Education England Programme – 'Inclusive Leadership'
eoeleadership.hee.nhs.uk/equality_and_diversity

Competency framework for E&D:
edsportal.leicspart.nhs.uk/lpt/Evidence/4_3/Competency_Framework_final.pdf

Diversity and equal opportunities training

Redressing inequality in healthcare and society means proactively helping people to reconsider attitudes and become more aware of their own biases.

What is it?

Diversity training is a set of instructional programmes or educational activities to facilitate positive interactions between groups, reducing prejudice and discrimination, and enhancing participants' skills, knowledge, and motivation to interact with a diverse range of other people (Pendry et al 2007, Hanover and Cellar 1998, Rynes and Rosen 1995).

Why is it important?

There is a clear and compelling need to cultivate a more diverse and effective NHS leadership. The NHS was created in 1948 based on the core value of inclusion – to provide care for all those who needed it, regardless of status, wealth, ethnicity, age, gender. However, cultures of inclusion rely on equity, fairness, justice and equal opportunities for all staff, of all backgrounds and social identities.

Discrimination continues to be widespread – in society and in the NHS (West et al 2015). Increasingly, research across the NHS identifies another factor that could compromise the quality of patient care and contribute to health inequalities: unconscious bias (Asch et al 2006, Cookson et al 2016, Francis 2013).

Unconscious bias is an implicit force that can work against inclusivity. It operates by self-categorisation. We make sense of others and ourselves by placing people into groups of those 'like us', or 'unlike us'. This occurs without our full awareness, guided by our implicit attitudes and assumptions about people we have experienced who are similar to those we are categorising (Greenwald and Banaji 1995).

So we might make implicit assumptions based on someone's gender, race, age, language, nationality or socio-economic status, for example. These implicit assumptions will affect the way we treat them – whether positively or negatively.

Stereotyping is a common form of bias. This involves generalising about people's characteristics and qualities depending on whether they are a member of the 'in-group' (perceived as 'one of us') or the 'out-group' (perceived as being different, or 'one of them'). People tend to classify those in their in-groups with more positive values and attributions. This helps them maintain a positive sense of self. In contrast, they will associate negative stereotypes with those in their out-groups. This can damage the perception of organisational justice and fairness (McMillan-Capehart and Richard 2005).

Stereotyping can be positive as well as negative – such as saying that certain demographic groups are particularly good at doing certain things. But all stereotyping is limiting and runs counter to inclusivity (Fiske et al 2002). Whatever the content of a stereotype, it will influence the way we treat others. This can create a negative cycle where our stereotypes are confirmed through the way people are treated (Chen and Bargh 1997, Cohen et al 2006).

Staff who experience an organisational culture where implicit attitudes and stereotypes go unchallenged or worse, are encouraged, may be more likely to deliver suboptimal care and put patients' lives at risk (Whelan 2013).

Find out more

If you are interested in diversity in the context of the NHS, it is important you read: Diversity, Identity-based talent management, Inclusion: listening to all voices and Minority focused leadership

What is the evidence?

An employee's demographic characteristics will have a major impact on their opportunities for challenge, leadership development and career progression (Douglas 2003). Staff who are female, or from BME or lower socio-economic groups are likely to be told they need more development, while receiving fewer opportunities for it (Munusamy et al 2010).

Better workforce representation leads to clear benefits for the organisation and its service users/patients (Hunt et al 2015). It is essential that leaders of organisations in the NHS quickly reflect the demography of the patient population they serve to minimise health inequalities. This is vital not only for moral reasons, but because there is evidence that diversity benefits organisational outcomes in the NHS (King et al 2011, West et al 2011).

Diversity training is important because the evidence tells us that bias has profound effects.

Evidence of bias

Green et al (2007) explored the effect of bias on drug prescribing through the implicit association test https://implicit.harvard.edu/implicit/index.jsp

The researchers gave 220 white medical doctors case studies of patients' symptoms and asked them to select drug prescription preferences for each patient. They found a strong link between the doctors' assumptions about the patients and their prescription choices. The doctors were less likely to prescribe effective drugs to black patients (see also Ziegert and Hanges 2005).

Another study, published by the Department for Work and Pensions (Wood et al 2009), found that of the 987 job applications with a traditionally white-British name 10.7% received a positive response. In comparison, of 1,974 applicants with minority ethnic names, only 6.2% were successful – a 4.5 percentage point difference. Most strikingly, discrimination against minority ethnic applicants was apparent despite there being nearly 1,000 more applications in this sample.

Evidence about training

Research suggests that conventional diversity training can boost individual knowledge and somewhat reduce reported discrimination in organisations (Bezrukova et al 2016). Beyond that, it has a limited effect on changing cultures, although some strategies appear more successful than others in bringing about wider positive change (West et al 2015).

Although individuals' attitudes and biases can compromise patient care and an organisation's vision for an inclusive culture, they can be trained and controlled.

If employees have a self-determined, internal motivation to manage their prejudices, this helps reduce discriminative behaviours and unequal opportunity (Devine et al 2002).

This is an important guiding principle for any initiative seeking to reduce implicit biases in the organisation.

However, if an employee's motivation is driven by external factors, such as a fear of blame or litigation, they are more likely to relapse and demonstrate anxiety or avoidance when interacting with people from their 'out-group' – people considered different (Plant et al 2010).

Evidence about impact of wider organisational culture

By this logic, NHS leaders need to positively reinforce inclusivity through compassionate interactions with others, to inspire an internal motivation in the people reporting to them to challenge exclusion, prejudice or discrimination. The alternative – adopting a 'command-control and punishment' approach – is likely to compromise diversity and inclusion efforts and even exacerbate the problem.

Some argue that the success of good diversity management practices relies on their being embedded in a culture that emphasises the inclusion of all (Thomas and Ely 1996).

A recent study of 60,602 NHS staff found a strong negative relationship between leadership ethnic representation and perception of mistreatment at work (Lindsey et al 2017).

Find out more

For a wealth of further evidence on this issue, plus information about The King's Fund's report *Making a difference*, commissioned by NHS England, to suggest strategies for lasting change, click here

How is it done?

Diversity or equal opportunities training programmes must be designed with compassion in mind. When unconscious biases are found to be at play, this means helping individuals attend to, understand and empathise with one another, taking intelligent action to minimise the bias and its negative impact.

This approach is the antithesis of a culture of command-control and blame. It nurtures non-judgmental and non-evaluative attitudes towards staff and patients alike.

This section proposes ways to address diversity issues at three levels – the individual, the team, and the organisation as a whole.

The individual level

There are several ways to address diversity issues at the individual level, through small, incremental but powerful changes. These should figure prominently in diversity training.

- Engage allies: Evidence suggests that allies from groups that do not face discrimination can confront and have an impact on others' discriminatory behaviour more effectively than members of under-represented groups alone.
- Set goals: Training programmes in which participants agree specific goals for their behaviour and attitudes, and review their progress, are more successful than interventions focusing simply on educating participants or encouraging discussion.
- Tackle subtle forms: It is important to educate staff, including leaders, about the subtler aspects of discrimination. However, more covert, opaque forms of discrimination continue. These might include negative humour, harassment or ridicule without overt discriminatory content. These are harder to identify, assess and eradicate.
- Avoid legitimising bias: Some messages communicated through diversity training interventions can have negative consequences. For example, saying 'most people exhibit unconscious race bias' can appear to legitimise that bias by labelling it as normative / normal. This can make some individuals less motivated to discover their own blind spots and change their attitudes and behaviours.
- Ensure access to all: Make sure professional development opportunities are accessible to all, tailored to diverse levels of English proficiency and sensitive to cultural and learning differences.

Approaches at the team level

Diversity training should focus on teamwork because it is within teams that most discrimination occurs. Opportunities for change are most likely to be effective here. The approaches likely to have most benefit encourage inclusion and value different perspectives.

Teams are more inclusive when they are well-structured and have:

- a positive and motivating vision of the team's work
- five or six clear, agreed, challenging team objectives
- regular, useful feedback on performance in relation to the objectives
- clear roles and good mutual understanding of these roles
- shared team leadership where the hierarchical leader does not dominate but supports and facilitates
- a strong commitment to quality improvement and innovation
- a culture of valuing diversity
- a pattern of listening to and valuing all voices in the team
- an optimistic, cohesive climate characterised by a high level of team efficacy
- co-operative and supportive ways of working with other teams in the organisation
- regular 'time out' and 'after-action' reviews to reflect on and improve team performance
- a team leader who reinforces the value of diverse voices, views, skills, experiences and backgrounds as vital for creativity, innovation, good decision-making and team effectiveness.

Approaches at the organisation-wide level

Training needs to be part of HR policies, practices and procedures that ensure effective diversity management policies, practices and procedures. Such organisational HR shapes and reinforces equal employment via approaches to (among other things):

- recruitment and selection
- promotion policies
- coaching and mentoring of under-represented groups
- mobility policies and the use of quotas to influence promotion decisions
- job security including, for example, additional approvals for terminating employees from protected classes
- appraisal processes, disciplinary procedures and rewards systems
- job design including workplace accessibility
- methods for encouraging staff participation in decision-making, information sharing, dialogue and interaction throughout organisations.

The Workforce Race Equality Standard

All NHS diversity training needs to educate staff about the Workforce Race Equality Standard (WRES) www.england.nhs.uk/about/equality/equality-hub/equality-standard/.

In 2014, the NHS Equality and Diversity Council agreed to ensure equal access to career opportunities and fair treatment in the workplace for employees from BME groups.

The NHS introduced WRES to help all NHS organisations take action. Now all NHS commissioners and providers are required to implement WRES and are assessed against the WRES standard.

Tips

- Ensure visible and sustained senior-management support for positive diversity and inclusion policies and practices.
- Equally important, make sure positive diversity and inclusion policies and practices are seen to be implemented effectively and consistently, and are reinforced by middle management and frontline supervisors.
- Continue to make moral arguments against discrimination as well as the business arguments. The human costs are huge and the impact on patient care is clearly negative and substantial. If staff experience discrimination, patients in these groups will be experiencing similar discrimination.
- Emphasise that many individuals, teams, organisations and national bodies in the NHS are now working hard to create a climate of fairness, inclusion, compassion and equality, to avoid implying that discrimination is 'normal'.
- Make sure that every individual, team, leader, organisation and overseeing body is encouraged in this area, through comprehensive and sustained efforts.

References

Asch SM, Kerr EA, Keesey J, Adams JL, Setodji CM, Malik S, McGlynn EA (2006) Who is at greatest risk for receiving poor-quality health care? *New England Journal of Medicine* 354 (11): 1147–1156

Bezrukova K, Spell CS, Perry JL, Jehn KA (2016) A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin* 142: 1227–1274

Chen M, Bargh JA (1997) Nonconscious behavioral confirmation processes: the self-fulfilling consequences of automatic stereotype activation. *Journal of Experimental Social Psychology* 33 (5): 541–560

Cohen GL, Garcia J, Apfel N, Master A (2006) Reducing the racial achievement gap: a social-psychological intervention. *Science* 313 (5791): 1307–1310

Cookson R, Propper C, Asaria M, Raine R (2016). Socio-economic inequalities in health care in England. *Fiscal Studies* 37 (3–4): 371–403

Devine PG, Plant EA, Amodio DM, Harmon-Jones E, Vance SL (2002) The regulation of explicit and implicit race bias: the role of motivations to respond without prejudice. *Journal of Personality and Social Psychology* 82 (5): 835–848

Fiske ST (2012) Managing ambivalent prejudices: smart-but-cold and warm-but-dumb stereotypes. *The Annals of the American Academy of Political and Social Science* 639 (1): 33–48

Francis G (2013) Developing the cultural competence of health professionals working with Gypsy Travellers. *Journal of Psychological Issues in Organizational Culture* 3 (S1): 64–77

Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR (2007) Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine* 22 (9): 1231–1238

Greenwald AG, Banaji MR (1995) Implicit social cognition: attitudes, self-esteem, and stereotypes. *Psychological Review* 102 (1): 4

Hanover J, Cellar D (1998). Environmental factors and the effectiveness of workforce diversity training. *Human Resource Development Quarterly* 9: 105–124

King EB, Dawson JF, West MA, Gilrane VL, Peddie CI, Bastin L (2011) Why organizational and community diversity matter: representativeness and the emergence of incivility and organizational performance. *Academy of Management Journal* 54 (6): 1103–1118

Lindsey AP, Avery DR, Dawson JF, King EB (2017) Investigating why and for whom management ethnic representativeness influences interpersonal mistreatment in the workplace. *Journal of Applied Psychology*. Available ahead of print at: www.ncbi.nlm.nih.gov/pubmed/28616999 (accessed 1 August 2017)

McMillan-Capehart A, Richard O (2005) Organisational justice and perceived fairness of hiring decisions related to race and gender: affirmative action reactions. *Equal Opportunities International* 24 (1): 44–57

Pendry LF, Driscoll DM, Field CT (2007) Diversity training: putting theory into practice. *Journal of Occupational and Organizational Psychology* 80: 227–250.

Plant EA, Devine PG, Peruche MB (2010) Routes to positive interracial interactions: approaching egalitarianism or avoiding prejudice. *Personality and Social Psychology Bulletin* 36 (9): 1135–1147

Rynes S, Rosen B (1995) A field survey of factors affecting the adoption and perceived success of diversity training. *Personnel Psychology* 48: 247–270

Thomas DA, Ely RJ (1996) Making differences matter. *Harvard Business Review* 74 (5): 79–90

van Dijk H, van Engen M, Paauwe J (2012). Reframing the business case for diversity: a values and virtues perspective. *Journal of Business Ethics* 111 (1): 73–84

West M, Dawson J, Kaur M (2015). Making the difference: diversity and inclusion in the NHS. London: The King's Fund. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf

Whelan J (2013). The barriers to equality of opportunity in the workforce: the role of unconscious bias. Chapter 4. In Committee for Economic Develop of Australia Understanding the gender gap. CEDA, Sydney: 55

Wood M, Hales J, Purdon S, Sejersen T, Hayllar O (2009) A test for racial discrimination in recruitment practice in British cities. Research report no 607. Department for Work and Pensions, London

Ziegert J, Hanges P (2005) Employment discrimination: the role of implicit attitudes, motivation, and a climate for racial bias. *Journal of Applied Psychology* 90: 553–562

Compassionate behaviour training

Compassion is essential in high quality healthcare. It comprises skills and behaviours that can be developed to ensure proactive and empathetic responses to patients, families and colleagues.

What is it?

Compassionate behaviour training develops the core skills of compassion. In an organisational context, compassion can be understood as having four components (Atkins and Parker 2012, Worline and Dutton 2017):

- attending – paying attention to the other and noticing their suffering
- understanding – what is causing the other's distress, by making an appraisal of the cause
- empathising – having an empathic response: a felt relation with the other's distress
- helping – taking intelligent (thoughtful and appropriate) action to serve the other or help relieve the other's suffering.

Why is it important?

Compassion is the core work value of virtually all NHS staff. Staff motivation, wellbeing and effort are sustained and nurtured in organisations where the core value is compassion. Compassionate care is also what patients want. It is therefore important to develop compassion among team members, among the team as a whole and as a feature of the organisation's culture.

Compassionate behaviour is manifested in interactions with patients/service users, carers, colleagues, fellow team members, other professional groups, our staff and anyone else we come across during the course of our work. The sum total of our interactions shapes the organisation's culture and that in turn has a direct effect on quality of patient care (West and Chowla 2017).

Contrary to widespread belief, compassion (and self-compassion) can clearly be learned and developed (Worline and Dutton 2017, Gilbert 2017). By focusing on the core behaviours underpinning compassion, we can develop our awareness of those in distress, and respond empathically and supportively. Indeed, much research evidence suggests compassion is a core neurophysiological response for virtually all of us, and is characteristic of what it is to be human (Gilbert 2017). Simple training and supportive organisational contexts can release the power of compassion in the workplace.

Find out more

If you are interested in compassion in the context of the NHS, it is important that you also read: Developing compassionate leadership and Compassion-based recruitment.

What is the evidence?

Much evidence suggests the four behaviours of compassion can be developed in organisations and shows the profound effects of creating compassionate cultures (Bell et al 2017, Worline and Dutton 2017).

But compassion also has inhibitors, so part of training is helping people to be aware of these. They include:

- poor working conditions, poor leadership, role confusion, role conflicts and work overload (Brown et al 2014, Gilbert and Mascaro 2017)

- the 'shackles of routine and ritual' – blamed for constraining compassion by hindering flexible, individualised and creative delivery of patient-centred care (Kelly 2007)
- difficult patients and families, complex clinical situations, and a focus on non-patient centred tasks and targets such as financial performance (de Zulueta 2016).

To see the full list, go to Compassion performance.

Leaders and all staff can nurture compassionate cultures by behaving with compassion (Kanov et al 2004). Compassion can spiral out, so that those receiving it are better able, or more likely, to be caring and supportive to others (Lilius et al 2011). This may well replenish the emotional resources that care-givers need, especially in a caring environment, and cushion against stress and burnout (Lilius et al 2011, Dutton et al 2014).

Experiencing compassion from others shapes people's views. For example, they may see themselves as more capable. They may view their peers as more kind. They may even change their perception of the kind of organisation they are part of (Dutton et al 2014). When staff feel valued and cared for (perceiving that they have organisational support), they tend to feel more satisfied in their jobs and be more committed to their organisations (Lilius et al 2011). In the NHS, this is associated with high levels of patient satisfaction, care quality and even financial performance (West et al 2011).

The theory of positivity resonance explains how moments of connectivity (such as interpersonal compassion) benefit people in an interaction through a natural synchronisation of bodies and brains, in ways that foster health and wellbeing (Fredrickson 2013).

How is it done?

We describe here what is needed to develop compassionate behaviour in relation to the four elements of compassion: attending, understanding, empathising and helping.

Attending

This involves being present with the other person – what Nancy Kline (2015) calls 'listening with fascination'. Two skills are relevant here. The first is mindfulness, which enables the person to stand back from their own thoughts for a moment, to notice what is happening for the other person. The other, closely linked, is self-compassion, which enables the person to treat themselves with kindness and understanding.

Mindfulness

Mindfulness training is about being more aware of oneself, others and the world around in each moment. People who are more mindful have higher levels of emotional intelligence, improved relationships and reduced levels of stress by developing a natural state of mind in which they are focused, present and aware (West 2016). They have more sustained attention and greater emotional regulation. They can better adopt different perspectives and, in particular, be more compassionate towards others.

Mindfulness courses are now taught in many organisations, including large corporations, schools, law courts, prisons, government agencies and Parliament.

Find out more: mindfulness

www.kingsfund.org.uk/leadership/developing-compassionate-leadership-through-mindfulness

http://oxfordmindfulness.org/

https://mbsr.co.uk/whatismindfulness.php

See also Ie et al 2014a and 2014b

Self-compassion

It is important to help health and social care professionals develop self-compassion because it is critical to the ability to be compassionate

towards others.

Find out more: self-compassion

www.mindfulcompassion.com/

http://self-compassion.org/category/exercises/#exercises

https://soundcloud.com/dennis-tirch-phd/01-compassionate-mind-training (introduction)

https://soundcloud.com/dennis-tirch-phd

www.mindfulselfcompassion.org/

http://centerformsc.org/

http://self-compassion.org/

Understanding

Like attending, understanding involves learning to listen carefully to another. Listening is a principal skill relevant to attending and understanding, and involves:

- active listening – putting effort into the listening process and being fully present with the other
- open listening – listening with an open mind and suspending judgement to let the individual work through an idea
- drawing out – encouraging others to talk about their ideas, feelings and aspirations, especially through open questions; asking why, how and who, to enable the other person to elaborate and articulate their own exploration of the issue
- reflective listening – restating your understanding of what the other person has said as a genuine attempt to restate and summarise the information they have given – to check your understanding and offer perspective on what they have described, by hearing it in someone else's words.

Empathising

To empathise we must recognise and reveal feelings and use our emotional intelligence to relate to the other person's experience, without being overwhelmed by it. Emotional intelligence underpins our interactions with others, representing a fundamental aspect of personality and behaviour – which is why training in it helps develop empathy.

Defining emotional intelligence

Salovey and Mayer (1990, p197) define emotional intelligence as:

> the capacity to reason about emotions, and of emotions, to enhance thinking. It includes the abilities to accurately perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth.

Individuals vary in their ability to process emotional information, but it can be learned. Emotional intelligence training focuses on four core behaviours:

- perceiving emotions – the ability to detect and decipher others' and one's own emotions
- using emotions – the ability to harness emotions to facilitate thinking and problem solving
- understanding emotions – the ability to comprehend emotion and appreciate relationships among emotions in the moment (moods and fleeting emotions) and over time
- managing emotions – the ability to regulate emotions in both ourselves and in others and to harness emotions, including negative emotions, and work with them to achieve goals.

Find out more: emotional intelligence

The London Leadership Academy, NHS England and others have developed these materials to promote emotional intelligence among NHS staff:

www.londonleadingforhealth.nhs.uk/sites/default/files/uploaded/Introduction%20to%20

Helping

This is enabled by social support, and can be learned. Staff can be trained to use four main types of social support – emotional, instrumental, informational and appraisal:

- emotional support – a shoulder to cry on, an encouraging word or sympathetic understanding of another's emotional pain
- informational support – doing practical things to aid team members, such as providing practical and helpful information (perhaps signposting sources of support)
- instrumental support – the practical, supportive actions that team members offer to one another in a crisis or simply as part of routine work; social support, in whatever form and at whatever time, has an important impact on the social climate, team members' wellbeing and the team's viability
- appraisal support – helping colleagues make sense of or interpret a problem; this need not involve offering solutions, but would involve helping the person examine alternative appraisals of any given problem.

For simple guidelines on how to develop compassionate behaviour, see here.

Guidelines for developing compassionate behaviour

Attending	Noticing at work is harder than we expect and when suffering goes unnoticed in organisations, compassion fails • Suffering is inherently difficult to express • Inquiry is crucial to awakening compassion • Time pressure, overload and performance demands distract us from noticing suffering at work • Policies, rules, and norms of conduct can orient us towards punishment rather than curiosity about what is happening with the other person • Presence and mindfulness are vital
Understanding	• Suffering is often masked by missed deadlines, errors or difficult and ambiguous work situations that trigger blame instead of compassion • Leaders can learn to be curious about the causes of difficult or ambiguous work situations as a way of cultivating more generous interpretations • All of us, particularly leaders, can practise cultivating the positive default assumption that others are good, capable and worthy of compassion – offering the benefit of the doubt • Leaders can withhold blame by steering conversations about errors or failure towards learning • We can imbue others with dignity and worth no matter what their role, position or difference from us • We can cultivate presence with suffering as a form of being authentically with others

Adapted from Worline and Dutton (2017)

Guidelines for developing compassionate behaviour *(continued)*

Empathising	• Fostering mindfulness is hugely powerful – an awareness of changing conditions in ourselves and others on a moment-to-moment basis. It helps us remain calm and steady in the face of suffering – our own as well as others'. http://oxfordmindfulness.org/ https://mbsr.co.uk/ www.mindfulcompassion.com/ • We can cultivate the capacity for attunement, which involves being aware of another person while staying in touch with our own somatic senses and experiences. We can heighten the sense of interconnection. • We can develop empathic listening, the capacity to tune in to feelings of concern as we hear others' perspectives and experiences. This allows us to be present without needing to fix, solve or intervene necessarily. • Empathy at work helps us 'feel our way forward' together and motivates compassion. • Identifying with others leads to empathy and a higher likelihood of compassionate action. • Feeling similar to the other contributes to identification. • Physical and psychological presence, conveyed through eye contact, verbal tone, posture and facial expressions, heighten identification.
Helping	• Compassionate acting involves spontaneity and improvisation and is directed by what is most useful for those who are suffering. • Skilful compassion involves taking actions that address suffering. • These include creating flexible time to cope with suffering, buffering someone from task overload, monitoring and checking in, generating resources that will alleviate suffering and designing rituals that convey support. • Compassionate action can be hindered by legalistic approaches that deny human connection. • Corrosive politics, toxic interactions, consistent underperformance and other forms of conflict at work are sources of suffering that must be addressed. They require 'fierce compassion.' • Compassion is reduced when people fear that they will be viewed as weak or vulnerable for giving or receiving compassion. • Importance of integrity and privacy.

Adapted from Worline and Dutton (2017)

Tips

The following are characteristics of successful behaviour training programme design (Yukl 2013) See also Woods and West (2014)

- Clear learning objectives: a limited number of clear objectives, to ensure appropriate focus.
- Clear, meaningful content: meaningful in relation to the training objectives , with periodic summaries of content and models that are simple enough for people to understand, remember and apply.
- Appropriate sequencing of content: present models before introducing the techniques derived from them. Progress from the simple to the more complex, with intervals to allow people to practise techniques and digest learning between sessions.
- Appropriate mix of methods: combine formal lectures, practice sessions, role plays, coaching or experiential exercises, as appropriate to the capacities of learners and skills being taught.
- Opportunity for active practice: ask trainees to restate the principles, try them out in a safe way then put them into practice in the workplace, with an opportunity to review effectiveness.
- Relevant, timely feedback: provide feedback during the training process.
- Promoting confidence: offer reassurance and praise. Start with simple tasks so trainees can experience success before moving onto more complex tasks.
- Follow-up activities: set specific tasks to be completed on returning to the workplace, with reviews of success and challenges faced.

References

Atkins PWB, Parker SK (2012) Understanding individual compassion in organizations: The role of appraisals and psychological flexibility. *Academy of Management Review* 37 (4): 524–46

Bell BS, Tannenbaum SI, Ford JK, Noe RA, Kraiger K (2017) 100 years of training and development research: what we know and where we should go. *Journal of Applied Psychology* 102: 305–323

Brown B, Crawford P, Gilbert P, Gilbert J, Gale G (2014) Practical compassion: repertoires of practice and compassion talk in acute mental healthcare. *Sociology of Health and Illness* 36: 383–399

Cole-King A, Gilbert P (2011) Compassionate care: the theory and the reality. *Journal of Holistic Healthcare* 8 (3): 29–37

de Zulueta PC (2016) Developing compassionate leadership in health care: an integrative review. *Journal of Healthcare Leadership* 8: 1–10

Dutton JE, Workman KM, Hardin AE (2014) Compassion at work. *Annual Reviews of Organizational Psychology and Organizational Behaviour* 1 (1): 277–304

Fredrickson B (2013) Love 2.0: How our supreme emotion affects everything we feel, think, do, and become. Hudson Street Press, New York

Gilbert P (2017) (ed) Compassion: concepts, research and applications. Routledge, London

Gilbert P, Mascaro J (2017) Compassion fears, blocks, and resistances: an evolutionary investigation. In Sappla E, Doty J (eds) Handbook of compassion. Oxford University Press, New York

Ie A, Ngnoumen CT, Langer EJ (2014a) The Wiley Blackwell handbook of mindfulness (vol 1). Wiley Blackwell, Chichester

Ie A, Ngnoumen CT, Langer EJ (2014b) The Wiley Blackwell handbook of mindfulness (vol 2. Wiley Blackwell, Chichester

Kanov JM, Maitlis S, Worline MC, Dutton JE, Frost PJ, Lilius JM (2004) Compassion in organizational life. *American Behavioral Scientist* 47 (6): 808–827

Kelly J (2007) Barriers to achieving patient-centred care in Ireland. *Dimensions of Critical Care Nursing* 26 (1): 29–34

Kline N (2015) *More time to think: the power of independent thinking*. Hachette, London

Lilius JM, Kanov J Dutton JE, Worline MC, Maitlis S (2011) Compassion revealed: what we know about compassion at work (and where we need to know more) in Cameron K, Spreitzer G (eds) The Oxford handbook of positive organizational scholarship. Oxford University Press, New York

Mannion R (2014) Enabling compassionate health care: perils, prospects and perspectives. *International Journal of Health Policy and Management* 2 (3) 115–117

Salovey P, Mayer JD (1990) Emotional intelligence. *Imagination, Cognition and Personality* 9 (3): 185–211

West MA (ed) (2016) The psychology of meditation: research and practice. Oxford University Press, Oxford

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In Gilbert P (ed) Compassion: concepts, research and applications. London: Routledge: 237–257

West MA, Dawson JF, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 29 July 2017)

Woods S, West MA (2014). The psychology of work and organizations. Second edition. Sage, London

Worline M, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler Publishers, Oakland CA

Yukl S (2013) Leadership in organizations (8th edition). Pearson Education, London

Identity-based talent management

Having a strong 'identity fit' – a feeling that one 'belongs' in an organisation – plays a strong part in employees' engagement and motivation. Proactively managing diversity can help improve retention and quality of care.

What is it?

Identity-based talent management focuses on encouraging all to achieve their potential and find a strong sense of 'identity fit' in their NHS organisations. This is especially relevant for members of groups traditionally subject to widespread and consistent discrimination.

The theory of social identity argues that our work and non-work lives interact to powerfully influence the extent to which we experience a sense of identity fit at work (Sools et al 2007). This sense is increased when an employee can positively identify with their colleagues and the organisation's leaders. Where the identity fit is high, employees are more committed, engaged and motivated. Where it is low, turnover and engagement are significantly lower.

Why is it important?

Despite targeted efforts to improve diversity, senior NHS leadership is dominated by 'snowy white peaks' (Kline 2014). In England, members of black and minority ethnic (BME) groups make up 14% of the patient population (ONS 2012). However, they represent 5.8% of NHS boards and are poorly represented among NHS chief executives (Kline 2014).

Women are also under-represented in senior NHS leadership roles, despite making up 77% of the general NHS workforce and being over-represented at junior levels (Newman 2015, Sealy 2017).

Workforce diversity improves patient care, minimises health inequalities and nurtures inclusive cultures (Mitchell and Lassiter 2006, Dreachslin et al 2000, West et al 2011). NHS organisations can improve the diversity of their workforce by tailoring their talent management practices to be more encouraging and accommodating of difference, increasing engagement, promotion and retention of minority group individuals.

Find out more

If you are interested in diversity in the context of the NHS, it is important you read: Diversity, Inclusive leadership, Inclusion: listening to all voices and Diversity and equal opportunities training

What is the evidence?

One research study, conducted among male and female junior surgeons, found that relative to women, men had a stronger identity fit, and self-reported as more similar to the consultant surgeon in their team (Peters et al 2013, 2015). The impact of identity fit is considerable, given that male surgeons who had stronger identity fit also scored higher on measures of career motivation and ambition for leadership.

A lack of fit can be caused by a lack of relatable role models for junior employees from under-represented groups.

Poor employee identity fit can lead to higher levels of turnover, reduced job satisfaction and increased perceptions of injustice (Ng and Burke 2005). A recent study of 60,602 NHS staff found a strong negative relationship between ethnic representation among leadership and perception of mistreatment at work (Lindsey et al 2017).

On the other hand, stronger identity fit can buffer against discrimination, bullying and abuse.

How is it done?

The issue can be tackled by managing diversity effectively, through talent management practices. Successfully implemented strategies and interventions that increase leadership diversity signal to junior employees that career progression is possible. This, in turn, increases the extent to which they identify with their occupation and their career ambition for leadership roles.

Here is how these can be tackled in different areas:

- Recruitment – Organisations that embed and explicitly communicate their commitment to diversity management attract applicants who are more diverse in gender and ethnicity (Avery 2003, Cox and Blake 1991). However, using recruitment to increase workforce diversity must be managed well. Positive discrimination in favour of minority identity-group applicants can have negative effects both for the individual and the perceptions of fairness from others in the organisation (Harris and Foster 2010).
- Development – Exploring similarities and differences in the social identities of staff in an organisation can be a rich resource for learning and insight. See 'Models to use', below for two models that place social identity at the core of leadership development.
- Promotion – While many diversity management strategies have hired and placed diverse employees effectively, the success rate of their retention and promotion is less reported. Addressing this involves implementing a clear strategy for promotion and succession planning of under-represented groups. This will involve using demographic data to intelligently monitor the representativeness of identity groups at various levels of the organisation (Cox 2001) and designing strategies to affirm diversity at every stage of their careers (Thomas 1990).

Two models to use

Social identity researchers have begun encouraging organisations to use identity diversity to maximise learning, innovation, organisational commitment and employee retention. Two models offer frameworks for this.

ASPIRe

To address the organisational challenges associated with social identity fit, Haslam and colleagues developed the ASPIRe model (Haslam et al 2003). This can shape talent management practices to accommodate different identity groups' unique and diverse needs.

The ASPIRe model has three-phases – three Rs:

- reflect – identify subgroup identities within the organisation
- represent – discover goals and aspirations of subgroups
- realise – appreciate and be made aware of the diverse ambitions of the group.

A growing evidence base supports the ASPIRe model, including its use with military medics (Peters et al 2013) and healthcare staff (O'Brien et al 2004). It has been found to increase identity fit for individual employees and to improve managers' and employers' understanding of people's unique needs.

AIRing

Building on the ASPIRe framework's success, Eggins et al developed AIRing: a social identity leadership programme comprising five steps:

- Readying – participants are educated about social identity formation and the importance of exploring social identity at work in relation to positive organisational behaviours.
- Reflecting – a social identity map is created by asking participants to name the group they most identify with in their organisation and the reasons for this, before exploring the relationships that this group has with other subgroups in the organisation (Eggins et al 2008).
- Representing – a workshop is run, enabling the subgroups to share their unique and shared aspirations, and establish the challenges and opportunities associated with their shared identity.
- Realising – a further workshop uses participative goal setting: a mechanism for creating shared and interdependent goals. This is designed to foster collectiveness and collaboration within and across organisational teams. This workshop brings subgroups together to co-design goals and strategies for improving their identity fit at work.
- Reporting – at this last session, subgroup members communicate the initiatives they are implementing and share their learning from exploring their social identities and those of their colleagues. They are then encouraged to remain champions for the work and become responsible for spreading the learning across the teams they lead.

A longitudinal study of organisational leaders (Wegge and Haslam 2003) has validated this framework as an innovative and effective approach to managing diversity, increasing self-awareness of social identity and supporting individual leadership development. This work's practical implications include applying the framework during employee induction, socialisation or transition from one role into another.

Tips

- Make sure recruitment, selection and performance management systems explicitly support under-represented or disadvantaged groups.
- Monitor progress towards continuing and rapid improvement in the representation of under-represented or disadvantaged groups in leadership positions at all levels.
- Using the Workforce Race Equality Standard, monitor progress to ensure continuing and rapid improvement in the experience of under-represented or disadvantaged groups in the organisation.

Find out more: The Workforce Race Equality

Standard www.england.nhs.uk/about/equality/equality-hub/equality-standard/

References

Avery DR (2003) Reactions to diversity in recruitment advertising – are differences black and white? *Journal of Applied Psychology* 88 (4): 672

Cox Jr T (2001) Creating the multicultural organization: a strategy for capturing the power of diversity. Jossey-Bass, San Francisco CA

Cox TH, Blake S (1991) Managing cultural diversity: implications for organizational competitiveness. *Academy of Management Executive* 5, (3): 45–56

Dreachslin JL, Hunt PL, Sprainer E (2000). Workforce diversity: implications for the effectiveness of health care delivery teams. *Social Science and Medicine* 50 (10): 1403–1414

Eggins RA, O'Brien AT, Reynolds KJ, Haslam SA, Crocker AS (2008). Refocusing the focus group: AIRing as a basis for effective workplace planning. *British Journal of Management* 19 (3): 277–293

Harris L, Foster C (2010). Aligning talent management with approaches to equality and diversity: challenges for UK public sector managers. *Equality, Diversity and Inclusion: An International Journal* 29 (5): 422–435

Haslam SA, Eggins RA, Reynolds KJ (2003) The ASPIRe model: actualizing social and personal identity resources to enhance organizational outcomes. *Journal of Occupational and Organizational Psychology* 76 (1): 83–113

Kline R (2014) The snowy white peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. Middlesex University, London

Lindsey AP, Avery DR, Dawson JF, King EB (2017) Investigating why and for whom management ethnic representativeness influences interpersonal mistreatment in the workplace. *Journal of Applied Psychology*. Available ahead of print at: www.ncbi.nlm.nih.gov/pubmed/28616999 (accessed 1 August 2017)

Mitchell DA, Lassiter SL (2006) Addressing health care disparities and increasing workforce diversity: the next step for the dental, medical, and public health professions. *American Journal of Public Health* 96 (12): 2093–2097

Newman P (2015) NHS women in leadership: plan for action. NHS Employers, London. Available at: www.nhsemployers.org/~/media/Employers/Publications/NHS%20Women%20in%20leadership_Br1322_WEB.pdf (accessed 29 July 2017)

Ng ES, Burke RJ (2005) Person–organization fit and the war for talent: does diversity management make a difference? *The International Journal of Human Resource Management* 16 (7): 1195–1210

O'Brien AT, Haslam SA, Jetten J, Humphrey L, O'Sullivan L, Postmes T, Reynolds KJ (2004). Cynicism and disengagement among devalued employee groups: the need to ASPIRe. *Career Development International* 9 (1) 28–44

Office of National Statistics (2012). Ethnicity and national identity in England and Wales: 2011. ONS, London. Available at: www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11 (accessed 1 August 2017)

Peters K, Haslam SA, Ryan MK, Fonseca M (2013) Working with subgroup identities to build organizational identification and support for organizational strategy: a test of the ASPIRe model. *Group and Organization Management* 38 (1): 128–144

Peters K, Haslam SA, Ryan MK, Steffens NK (2015) To lead, ASPIRe: building organic organizational identity. In Otten S (ed) (2014) Towards inclusive organizations: determinants of successful diversity management at work. Psychology Press, New York: 87–107

Sealy R (2017). NHS women on boards by 2020. NHS Employers, London. Available at: www.nhsemployers.org/~/media/Employers/Publications/NHS%20Women%20on%20Boards%20report.pdf (accessed 29 July 2017)

Sools AM, Engen MV, Baerveldt C (2007). Gendered career making practices: on doing ambition or how managers discursively position themselves in a multinational corporation. *Journal of Occupational and Organizational Psychology* 80 (3): 413–435

Thomas RR (1990) From affirmative action to affirming diversity. *Harvard Business Review* 68 (2): 107–117

Wegge J, Haslam SA (2003) Group goal setting, social identity, and self-categorization. In Haslam SA, van Knippenberg D, Platow MJ, Ellemers N (eds) (2014) Social identity at work: developing theory for organizational practice. Psychology Press, New York: 43–59

West M, Dawson J, Admasachew L, Topakas A (2011) NHS staff management and health service quality. Department of Health, London

Additional useful resources

Further resources which will help your work in this area

Includes tools for Values Based Recruitment and a readiness Checklist
www.nhsemployers.org/your-workforce/recruit/employer-led-recruitment/values-based-recruitment/learn-about-vb

Section on Self Awareness and wellbeing that also has emotional Intelligence resources
www.londonleadingforhealth.nhs.uk/leadershiptoolkit/managing-self/self-awareness-and-well-being

From NHS England: Leading with Compassion, including guidance on compassion in practice
www.england.nhs.uk/wp-content/uploads/2014/12/london-nursing-accessible.pdf

The NHS Leadership Academy: The Edward Jenner on line programme covers a range of topics including: Leadership behaviours for person centred care, emotional intelligence and leadership effectiveness. This is accessible to all NHS staff following a short registration process:
www.leadershipacademy.nhs.uk/programmes/the-edward-jenner-programme/

The NHS Leadership Academy: information on programmes and resources including TRUST- an essential guide for effective and inclusive leadership and the IncLeaD toolkit:
www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/

The institute for Health Improvements web page contains a range of resources including this recent white paper on 'Joy in work':
www.ihi.org/Topics/Joy-In-Work/Pages/default.aspx

Case Study 8

Who
Derby Teaching Hospitals NHS Foundation Trust

Programme name
Supporting staff wellbeing through Schwartz Rounds

What was the aim?

Introducing Schwartz Rounds can provide time and space for staff to reflect on the emotional and social aspects of their work. The underlying premise is that the compassion staff show can make all the difference to a patient's experience of care, and to provide compassionate care staff must, in turn, feel supported in their work.

Schwartz Rounds provide a structured forum where staff from all disciplines come together to discuss the emotional and social aspects of working in healthcare. They help reduce feelings of stress and isolation and foster greater collaboration. The format for a Schwartz Round involves a panel sharing stories on a particular theme, followed by a facilitated discussion to explore the issues.

What did they do?

In 2016, Consultant Surgeon Gill Tierney was reflecting on how her work was affecting her when a colleague suggested she might benefit by taking part in a Schwartz Round.

She canvassed opinions among colleagues, and got the chief executive's support to introduce Schwartz Rounds at the trust. A business case to buy a licence for the Schwartz Rounds was successful, funded by Derby Hospitals Charity. The team that planned and implemented the Rounds comprised two clinical leads, two clinical facilitators, a deputy general manager and admin support. It was helped by the Point of Care Foundation, which is licensed to support Schwartz Rounds in the UK.

The clinical leads were essential for driving the work, consulting staff to identify the themes and promoting clinical engagement in the Rounds.

Since the trust introduced Schwartz Rounds in February 2017, 200 clinical and non-clinical staff have attended five monthly events. These take place on different days of the week and at different times to include all staff irrespective of shift patterns.

Gill Tierney, Schwartz Clinical Lead, says: "During a round, the sense of engagement from the audience is palpable. The positive effect seems to continue outside the round, with more smiles in the corridor, more dialogue, more of a feeling that we are all together doing this thing we do and a general sense of happiness".

Sam Walker, Schwartz Facilitator, says: "It's a great privilege to create and hold a space for everyone to come and be heard without judgement. The Schwartz Rounds show how we live our values".

Kara Dent, Schwartz Clinical Lead, says: "The feedback has been truly humbling from all fields. It builds a feeling of being valued and given time outside our crazy world of healthcare – a chance to share experiences and be inspired by others".

Diane Reeves, Schwartz Facilitator, says: "Being part of the Schwartz Rounds has been a breath of fresh air in a world full of targets and money saving. It has reconnected me with the core work we do and the amazing staff we have".

What were the outcomes?

Staff value the Rounds highly: 99.8% of those attending say they would recommend attending to a colleague, and 99.8% rate the Rounds positively – 15% as good, 47% as excellent and 38% as exceptional.

"Today was brilliant. I didn't realise other people felt the same, and this just made me realise I'm not the only one who feels like this."

"Great questions from the audience member on how supported the panellist felt and how we gain support from the challenging situations that we face. Summary of giving our emotions 'air time' and being kind to ourselves and others."

"It was good to see people that you would generally see in other roles joining together to share thoughts."

"Sceptical at points but panel experience useful and reflective for own behaviour."

"I thought that the panellists were incredibly brave and gave very vulnerable, powerful stories."

"I found this session very powerful and insightful. I would definitely want to attend again."

"Excellent source of support – a great help realising you are not alone – most of us probably carry distress but never speak about it – thank you!"

"Very powerful and inspiring."

What was the learning?

The team took care to communicate the Rounds' purpose and value in terms of the benefits to individuals. It purposely stayed away from the usual channels for corporate communications to avoid staff feeling this was just another corporate initiative.

The Schwartz Rounds licence is a significant investment over two years and it is important to ensure the business case includes VAT, travel to training, lunch/breakfasts.

Think about how the project team is made up and the kinds of people you want to attract to the Rounds. Derby Hospitals found that having doctors in the project team made it easier to attract doctors to take part in the Rounds. Ensure team roles are clear and cover all tasks required for successful Rounds.

Keep marketing and promoting the Rounds by attending internal conferences, team meetings, etc.

Provide a comfortable environment for staff and adapt it according to participants' feedback. Derby Hospitals found that rooms with chairs in a horseshoe shape worked best, and provided relaxing music while people ate.

For further information please contact:
rachel.jerram@nhs.net

References

www.theschwartzcenter.org/supporting-caregivers/schwartz-center-rounds/

www.pointofcarefoundation.org.uk/

Derby Teaching Hospitals NHS Foundation Trust did not use NHS Improvement's culture toolkit in its current form, but having worked with The King's Fund previously it has continued its culture journey to ensure improvements, acknowledging the importance of developing compassionate, inclusive cultures.

Case Study 9

Who
Central Manchester University Hospitals NHS Foundation Trust

Programme name
Reverse mentoring scheme

What is a mentor?
As part of Central Manchester University Hospitals NHS Foundation Trust's commitment to equality and diversity, a reverse mentoring scheme was established.

A mentor provides support and guidance to help an individual with their role, career and professional or personal development. As well as helping the mentee, they can develop their own skills and understanding. The term 'reverse mentoring' was used in 1999 by Jack Welsh, chief executive of General Electric, when he identified that the young could teach the old, and a mentor had as much if not more to learn from their mentee as vice versa.

What was the aim?

The Trust's reverse mentoring scheme at CMFT has two aims:

- to support the development and progression of staff in three protected characteristic groups – black and minority ethnic; disabled; and lesbian, gay, bisexual and transgender – which are under-represented at the trust compared to the local population
- to increase senior leaders' awareness of what it is like to work at the trust as an individual with a protected characteristic.

What did they do?

Senior leaders were invited to join the scheme and given support and guidance to understand their mentoring role. The trust's diversity networks used an online questionnaire to invite staff with a protected characteristic to take part. Staff were asked to share their protected characteristic and their areas of interest. They were matched to a senior leader with similar interests, who would act as their mentor.

The mentee contacted their mentor to arrange the first meeting – at least three meetings were advised. Mentor and mentee agreed ground rules and areas for discussion, and the mentee was encouraged to share their experiences of the organisation's culture. Topics discussed included: work-related experiences, work-related issues, career development, leadership development, learning and development, problems and challenges, skill development, personal experiences, values, teamworking and support requirements.

What were outcomes?

The scheme has existed since 2014 and has had two recruitment rounds. it was publicised through staff networks and equality advocates. Participants have reported the main benefits as increased understanding of other people's perspectives and development support: 91% of respondents said they had learned from participating. All reported increased knowledge and awareness of the purpose of mentoring, its benefits to an individual and the organisation (and patients), how they would develop themselves and their career, and what it was like to work at the trust with a protected characteristic.

What was the learning?

The main learning points included allowing mentees to volunteer, but actively encouraging senior leaders to participate. Some senior leaders did not appreciate the skills and experience they could share, or that their insights would be valuable to others and they could learn from the experience. Mentoring skills training was offered to those wanting to take part but lacking confidence to participate. The key message was that the relationship was informal, would evolve and did not require formal skills, unlike a traditional 'coaching' relationship.

Participants' comments included:

"This scheme is brilliant and I have really enjoyed it so far."

"Overall process very positive opportunity. Feel very lucky to have secured the time and skill of my mentor. Put me at ease straight away, could draw out key areas quickly, can see why we will benefit from her expertise at the trust, clearly talented. Perfect match for me, and come at the perfect time, thank you."

"That sometimes my mentee feels responsibility for championing diversity on their own. That our teams need to understand social exclusion in more detail. My mentee has a strong understanding and works hard to share this with her teams but often feels she is the only one doing this."

The scheme enabled people who would not normally meet to share experiences and learn from each other, applying insight and understanding to their day-to-day lives that has enriched the organisation's supportive culture.

For further Information please contact:
Stacy.Bullock@cmft.nhs.uk

Case Study 10

Who
Northumbria Healthcare NHS Foundation Trust

Programme name
Developing a coaching culture

What is coaching?
Coaching is a collaborative relationship between a coach and client, which is formed for the purpose of supporting the client to attain their professional or personal goals (Grant, Passmore, Cavanagh and Parker, 2010).

A coach supports someone at work to improve their performance by helping them reflect on, explore and clarify challenges at work, set objectives and review performance.

A coaching approach helps individuals to think through choices and options rather than simply giving instructions.

What was the aim?

Northumbria Healthcare NHS Foundation Trust wanted to broaden the opportunities for professional development it offered staff, while reinforcing the trust's values. It therefore set about introducing a coaching culture.

The trust wanted to build coaching capability and capacity in a group of leaders and managers who would offer their services to colleagues. It hoped that staff at all levels could be coached effectively and would be encouraged to become coaches themselves.

Northumbria Healthcare wanted to underpin its values, including 'accountability and responsibility' and 'everyone's contribution counts'. It also felt the approach would increase a sense of collective leadership – empowering individual staff to deliver high quality care.

What did they do?

The programme followed these steps:

- Commissioned an external, highly skilled and well-regarded Institute of Leadership and Management accredited coach/trainer to plan an approach and select a development framework.
- Identifying a group of leaders and managers keen to develop themselves and become knowledgeable, skilled, confident coaches who can offer coaching services across the trust.
- Developing a flexible framework for coaching development, such as a Level 5 or 7 ILM qualification or a non-accredited coaching development programme, for broad appeal.
- Buying in supervision services to ensure the new coaches receive continuing professional development.
- Identifying a coaching co-ordinator in the human resources/organisational development team to manage the coaching process: matching coaches to clients, discussing referrals or nominations, and acting as the conduit between coaches, clients and supervisors.

- Developing a communications plan to promote access to coaching services across the trust, using a variety of media.
- Agreeing measures of success that confirm the service is achieving its intended aims.
- Evaluating the effectiveness of the coaching, asking coaches and clients to say what is working well and what could be improved.
- Reaching out to coaches trained by other organisations (such as the Leadership Academy) and offering them opportunities to take part in activities run by the Trust Coaching Network.
- Joining the Association for Coaching to access continuing professional development and associated resources and keep abreast of best practice in the field.

What were the outcomes?

An active pool of qualified and experienced coaches is now available in the trust so that all clients can be matched to a coach – which has consistently been achieved.

A recent evaluation indicated that 67% of clients felt 100% of their coaching goals had been met. Respondents also reported improved work-life balance, improved health, increased confidence, loyalty and commitment to the trust.

Asked what they thought would have happened to them had they not received the coaching, clients' two most common responses were a high likelihood of sick leave due to stress, or leaving the trust due to dissatisfaction and low morale.

The costs of training the two groups of coaches was less than the cost of these two scenarios (covering staff off sick for four weeks or more, and recruiting to replace staff who would have left). This indicates a compelling return on the initial investment.

News of this approach travelled fast within the trust, and nursing and consultant teams requested group coaching – a different approach that we are evaluating and which is showing positive early results.

What was the learning?

- Because some staff were nominated to be coaches, rather than being invited to volunteer, some of them later pulled out. However, they still became champions or advocates for coaching.
- Working alongside communications colleagues to market and promote coaching, as well as develop case studies and testimonials, helped to change the prevailing perception of coaching as a remedial solution to address failings, rather than a positive development intervention.
- Describing requests for coaching as 'referrals' reinforced the image of coaching as a remedial activity. So instead, we used the word 'nomination'. Individuals could self-nominate or be nominated by their manager, or they could access coaching through a development programme, such as existing management or leadership programmes.
- Some staff viewed coaching with suspicion and cynicism, placing greater value on formal training, such as classroom-based courses and accredited programmes. The team tackled this through a soft launch approach, with coaching as just one part of a blended learning and development portfolio. Perceptions and preconceptions of coaching have now started to change and this is reflected in the increasing demand for coaching.

- Now that the appeal of coaching as a development intervention has been tested, a series of 'Manager as Coach' workshops will take place to enable line managers to develop their coaching skills and behaviours.
- To build in-house capacity and reduce reliance on external support in the longer term, the team is developing a small pool of existing coaches to become coaching supervisors.

One staff member commented: "I've experience improved confidence, increased clarity and improved wellbeing as a result of coaching. It's enabled me to be more rounded in perspective and in my reflections. Had I not accessed the coaching I don't think I would have secured my recent matron post".

For further Information please contact:
Kristina.Henry@northumbria-healthcare.nhs.uk

Case Study 11

Who
NHS North West Leadership Academy

Programme name
Mentoring scheme

What was the aim?

We set up the scheme in 2004, initially to support the new NHS national management development initiative. Commitment to the scheme was almost immediate and has continued to grow.

We wanted to:

- inspire individuals at all levels to take a proactive approach to their personal development
- empower individuals to innovate, take personal responsibility and demonstrate leadership in their roles
- increase people engagement at all levels
- build individual and organisational resilience
- promote inclusivity
- improve individual and organisational performance
- develop talent to support organisational development and succession planning
- deliver more effective outcomes for patients and service users.

What did they do?

The NHS North West Mentoring Scheme (NWMS) was established as a shared service for staff at all levels in the region. Mentees can apply to be matched to an appropriate mentor in the North West and attend quarterly mentee awareness sessions. Staff can apply to be mentors and undertake a mentor development day. They can also undertake regular continuous professional development (CPD).

As the benefits of mentoring became better understood, organisations asked for help to set up their own mentoring cultures. We therefore devised the role of 'mentor champion'. They develop internal mentoring schemes in their own organisation with NWMS support.

What were the outcomes?

The scheme generally achieved all the aims we outlined for it (see above).

Specific impact/benefits of mentoring to:		
The mentee	The mentor	The organisation
Increased self-confidence	Personally empowering, re-energising and rewarding	Staff care equals patient care
Increased self-awareness	Increased job satisfaction – reinforces how an individual role links to organisational purpose	Supporting the link between an individual role and the impact on patient care
Increased perception of support	Increased self-confidence	Maximising individuals' potential
Broadened perspective and understanding	Increased reflective practice	Collective improvements in individual performance leading to improvement in organisational performance
Support to prioritise and challenge	Networking	Increased skill level/skill transfer
		Focuses on relationships
		Cross-organisational collaboration
		Development offer

What were the learning points?

We faced several challenges in implementing and maintaining a North West wide scheme:

Senior level commitment:

Senior level support was essential for the scheme's ongoing development and sustainability. The steering group was chaired by a passionate and enthusiastic local chief executive who understood the benefits mentoring could bring. We invited board members across the North West to become mentors, held roadshows and a high profile launch. We issued regular updates and publicised the benefits. The scheme was described as an integral part of the NHS North West Leadership Academy membership.

Perception of mentoring as the 'soft and fluffy stuff'

Again, high level sponsorship helped with this, promoting evaluation findings including recent research. Multiprofessional Involvement, including medical consultants and reputable field leaders (David Clutterbuck, Management Futures), helped spread the message. Some clinicians who underwent clinical supervision understood that the scheme offered something different and became great advocates.

Managing the supply and demand of mentors

The Academy's mentor team supports mentors and mentees with the online Mentor Net software system with individual guidance if required and by promoting CPD networking events to ensure we

have sufficient mentors. With high demands on all leaders, it is essential we maintain support for our mentors when the need for them is at its greatest.

Mentor competencies

We provide ongoing CPD and networking to ensure mentors keep their skills up to date and feel comfortable supporting and challenging mentees. They can register their development on the online Mentor Net system. The current focus is on ensuring mentors and coaches promote inclusivity in their practice.

Inclusivity of the scheme

We are increasingly aware of the need to ensure mentees are representative of the population they serve. The scheme must continue to be inclusive of those with protected characteristics and more broadly. We must ensure all our staff have the means and support to become effective leaders and that we actively support their career aspirations. We have addressed some of this through CPD for coaches and mentors.

Future of the scheme

Our vision is a future where developmental mentoring is embedded in every health and care organisation as a fundamental pathway to a culture of compassion, innovation, integration and leadership to enable the best possible health and care for all.

Working with other development partners in the North West, and those responsible for developing local authorities and the wider public sector, the Academy already offers cross-sector mentoring and coaching exchange schemes.

For further Information please contact:
deborah.davis11@nhs.net

- Developing cultures of innovation
- Leading for innovation
- Recruiting for commitment to innovation and quality improvement
- Development for managing innovation
- Leading for quality improvement
- Secondments
- Developmental assignments
- Action learning
- Action learning sets

Developing cultures of innovation

Cultures of innovation do not simply emerge within organisations: they need to be carefully nurtured through compassionate leadership that inspires vision, encourages collaboration and balances support with autonomy.

What is it?

Organisations can be described in terms of their cultures: meanings, values, attitudes and beliefs, or 'the way we do things around here' (Schneider et al 2017).

Innovative cultures have these features (West and Richter 2007):

- a firm and shared belief among most staff in an appealing vision of what the organisation is trying to achieve
- a high level of interaction, discussion, constructive debate and influence among staff as they go about their work
- interpersonal and intergroup relationships characterised by trust, co-operative orientations and a sense of interpersonal support and safety
- organisational members who are consistently positive and open to members' ideas for new and improved ways of working, providing both encouragement and the resources for innovation – particularly those at the upper echelons (and there are few echelons)
- the ability to work to demands that are manageably high, with members under pressure but seeing this as a positive and manageable challenge rather than an impossible burden.

Why is it important?

Only innovation can enable modern healthcare organisations and systems to meet the radically changing needs and expectations of the communities they serve. Adequate financial support is a necessary precondition, but it is clear that more money on its own, without transformative change, will not be enough (West et al 2017).

When organisational and systems environments are conducive to innovation generally, and to quality improvement specifically, attempts to meet the challenges of modern healthcare are more likely to succeed. Leadership is central to this. Compassionate leadership, in particular, is a fundamental enabling factor that will create a culture of improvement and radical innovation across healthcare.

What is the evidence?

Cultures of innovation have six key elements that organisations and systems need to ensure compassionate leadership (West et al 2017). They are shown in the figure below and explained beneath.

Tip: This section is a summary of the report Caring to change (West et al 2017). For more detailed evidence, see the full report at: www.kingsfund.org.uk/publications/caring-change

1 Inspiring vision and strategy

If an organisation or system wants to foster innovation and quality improvement, it must have an inspiring vision and strategy focused on high quality, continually improving and compassionate care. Fundamentally, all leaders need to demonstrate an unwavering, daily focus on the vision and strategy. They must nurture optimism and a sense of efficacy about progress towards the goals that are inherent in the strategy (Dixon-Woods et al 2013, Schneider et al 2017).

So visions and strategies must be translated into a limited number of manageable priorities. Creating cultures focused on high quality, compassionate care requires good management of performance by ensuring clear, aligned and challenging objectives for all teams at all levels, focused on providing such care (West et al 2014). These conditions also facilitate innovation.

2 Compassionate and collective leadership

Compassionate leadership enhances the natural motivation of NHS staff and reinforces their fundamental altruism. It helps to promote a culture of learning that encourages risk taking (within safe boundaries), and accepts that not all innovation will be successful. This is the opposite of a culture characterised by blame, fear and bullying.

Compassion also creates psychological safety, so that staff feel confident in speaking out about errors, problems and uncertainties. They feel empowered and supported to develop and implement ideas for new and improved ways of delivering services. In a compassionate culture, staff also work more co-operatively and collaboratively in a climate characterised by cohesion.

Compassionate leadership also addresses the problem of work overload by ensuring workload and resources are aligned. Overload damages employee health and inhibits effective innovation.

The idea of compassionate leadership also implies a collective approach: leadership of all, by all, for all. This means everyone taking responsibility for ensuring positive inclusion and participation (West et al 2014).

3 Positive inclusion and participation

In the NHS, learning and innovation (with psychological safety rather than a blame culture) is vital to nurture a culture of high quality, continually improving and compassionate care.

Key features of a psychologically safe culture include:

- voices of staff and service users being constantly heard by leaders (Berwick 2013, Dixon-Woods et al 2013)
- team members paying attention ('listening with fascination') to each other, developing mutual understanding, empathising and supporting each other (West and Markiewicz 2016)
- higher levels of learning and innovation (Edmondson 1999)
- a diversity of perspectives contributing to the pool of task-related skills, information and perspectives (Milliken and Martins 1996, Simons et al 1999)
- diverse perspectives and information being properly processed, to produce effective decision-making and high quality patient care (De Dreu 1997, Hoffman and Maier 1961, Pearce and Ravlin 1987, Porac and Thomas 1990, Paulus 2000, Tjosvold 1985, 1991 and 1998).

A culture of positive inclusion values diversity (which is key for creativity). But this diversity of people, inputs and voices must be complemented by a culture of consistently positive attitudes to difference (of opinion, professional background, experience and demographic features).

4 Enthusiastic team and cross-boundary working

This relates to work within teams, between teams and across systems.

Within teams

Working in teams is vital for healthcare quality, but there is also good evidence that supportive teams, with compassionate team leadership, have significantly lower stress levels than dysfunctional or 'pseudo' teams in healthcare. (A pseudo team is a group of people that does not really comprise a team. For example, they may have no interdependence, no joint goals that they are striving to achieve, or no distinctive function or role within the organisation.)

The more staff work in these teams, the lower the stress levels, errors, staff injury, harassment, bullying and violence against staff, absenteeism and (in the acute sector) patient mortality (Carter and West 1999, Lyubovnikova and West 2013, Lyubovnikova et al 2015, West and Markiewicz 2016).

Good team leadership ensures connection and compassion across boundaries so that healthcare staff work together across professions to deliver high quality care (West and Lyubovnikova 2012, West 2012).

The more that high quality teamworking is implemented in organisations, the higher the levels of innovation and quality improvement – in healthcare specifically, but also in other sectors (West et al 2003).

Critically, teams must regularly take time to review performance to develop new and improved ways of working, resulting in sustained high levels of innovation (Schippers et al 2015).

Between teams

Teamworking also relates to inter-team working. A core objective of any team in modern healthcare must be to demonstrate enthusiastic cross-boundary co-operation to ensure that supportive inter-team, cross-boundary and systems working is the norm (Richter et al 2006). This leads to less conflict between groups and more collaboration between teams. Overall, it is one of the most powerful levers to increase the quantity and quality of organisational innovation (Richter et al 2006).

Across systems

The need for compassionate leadership co-operation across boundaries is not only important within organisations, it is needed between and beyond individual organisations too (see Hulks et al 2017).

5 Skills, capabilities, systems and processes for innovation

Ensuring cultures of high quality, continually improving care involves building the skills for improvement and innovation – in effect, empowering all staff to innovate and improve.

This requires leadership with the skills and focus to support innovation and improvement, and an understanding of the conditions for innovation. This includes understanding the innovation process: from problem identification and exploration to idea generation, evaluation, selection, implementation and review.

Skills need to be developed through well-understood processes, adapted from other organisations and sectors, for assessing and supporting innovation projects (stage-gate processes, for example). Rewards, recognition and resources for innovation projects must be readily available.

6 Support and autonomy

The more positive staff are about their working conditions, the more positive patients are about their care. This has been confirmed in longitudinal analyses (Dawson et al 2011). Similar findings emerge from other studies examining the relationship between nurse leadership and patient outcomes (Wong and Cummings 2007). These conditions favour innovation.

When leaders show compassion, and support staff to cope with the inevitable negative experiences of healthcare (for example, patient fear, suffering, anger or grief), this elicits engagement and creativity. And when leaders take time to help staff process negative experiences, they enable them to experience positive emotions and greater work-focused creativity (Bledow et al 2013).

Research into individual, team and organisational-level innovation shows consistently that autonomy is an important enabling condition for innovation (Mumford and Licuanan 2004). Creating the conditions for innovation involves giving frontline teams autonomy to experiment, discover and apply new and improved ways of delivering care (Liu et al 2011, Somech 2006). Releasing the capacity for innovation is more likely to take place when staff are supported and given discretion, control and freedom for service improvement (Hirst et al 2011).

Finally, organisations that have low levels of formalisation, bureaucracy and hierarchy but high levels of autonomy and discretion are significantly more innovative when it comes to new services, products, technologies, processes and administrative procedures (West and Richter 2007).

How is it done?

Developing a culture of innovation requires a wide programme of activities and approaches. Organisations that have done this have key features in these categories:

- inspiring vision and strategy
- compassionate and collective leadership
- positive inclusion and participation
- enthusiastic team and cross-boundary working
- skills, capabilities, systems and processes for innovation
- support and autonomy.

Each of these is described over the following pages.

Inspiring vision and strategy

- There is a clear statement of organisational strategy, vision and purpose focused on providing high quality, continually improving and compassionate care
- All departments, directorates, teams and staff understand and identify with organisational vision and purpose
- This vision and purpose are translated into a few, clear, challenging objectives at every level, which drive quality improvement and innovation throughout the organisation for every department, team and (where appropriate) individuals
- Teams have helpful information on their progress towards objectives often enough to enable high quality performance and quality improvement
- The organisation has breadth, depth, continuous review and effectiveness in its strategic planning, ensuring an emphasis on innovation
- The organisation generates radical new ideas and challenges conventional thinking during strategic planning
- The organisation seeks sustained and authentic involvement of all key stakeholder groups in strategic planning.

Compassionate and collective leadership

- There is a norm of compassionate leadership across all levels of the organisation, with good understanding of the key behaviours (attending, understanding, empathising and helping/serving
- The organisation recruits and selects for compassionate leadership
- There is in-house development of compassionate leadership
- Leadership offers inspiration and articulates a compelling vision for the future
- Leaders create positive emotional environments characterised by optimism, gratitude, appreciation and humour
- The chief executive and senior-team members inspire and foster innovation and experimentation within safe boundaries
- The senior-team leadership is diverse and has high levels of reflexivity (reflecting on team objectives, strategies and processes and adjusting as necessary)
- At every level, there are team reflexivity and after-action reviews, which determine what performance was expected, what variations there were in performance, and what can be learned and changed
- There is well-developed collective leadership, with everyone taking responsibility for leadership, regardless of their hierarchical position
- Teams have shared leadership
- Leaders work interdependently across the organisation
- There is a shared and consistent approach to leadership that is supportive and embodies listening, enabling and facilitating staff
- All leaders strive to be authentic, open, compassionate, positive and appreciative.

Positive inclusion and participation

- There is a good understanding of, and reflection on, patient needs across the organisation
- The organisation has effective methods for authentically engaging patients, carers and the community in strategy development, service redesign, governance and innovation
- There is significant diversity in experience and backgrounds at different levels
- The senior management team contains a diversity of experience and perspectives
- Everyone values this diversity of perspective and background
- There is sustained development of a positive climate, with positive moods and emotions – humour, warmth, efficacy, cohesion and optimism
- There are high levels of recognition and appreciation of contributions top to bottom and end to end
- There are low levels of aggressive, intimidating, bullying, discriminatory or harassing behaviours
- There is a learning-oriented attitude about near misses, errors and change, with people asking, 'What can we learn from this?' rather than 'Who can we blame?'
- The organisation encourages people to speak up and to dissent
- There are high levels of consultation with staff in general and opportunities for involvement, through schemes such as 'Listening into Action'
- Staff are supported to propose ideas resulting in improved care, reduced costs and increased staff wellbeing
- The organisation is involved in partnerships and networks, including other NHS and social care organisations and organisations from other sectors and countries

Enthusiastic team and cross-boundary working

- A high percentage of staff work in real teams with clear shared objectives, a high level of task and goal interdependence, clear role understanding and regular reviews of performance and how it can be improved
- A high percentage of teams are multidisciplinary as well as diverse in other ways
- Teams value difference and diversity and are characterised by shared leadership, flat structures, interprofessional collaboration, positivity and mutual respect
- Senior management teams work as teams, modelling outstanding teamwork, with a set of clear, shared, challenging objectives focused on how they will collectively support the organisation to achieve its purpose
- There are high levels of co-operative inter-team work, with team communities working together to prioritise effectiveness overall, rather than just their individual areas
- There is boundary-spanning co-operation with other organisations characterised by a shared and challenging vision, a commitment to long-term stability and continuity in the relationship, frequent face-to-face contact, conflict resolution that is speedy, transparent and fair, and a commitment to supporting partnerships with other teams or departments
- Teamworking is supported through structures such as team rewards, support for team innovation, initiatives that enable inter-team communication processes, team appraisals, and HR-led training for team leaders and teams
- Teams are energetic, enthusiastic and have a positive team affect, characterised by constructive management of conflict and a climate in which it is safe to learn
- Team members believe they work in a co-operative group context that emphasises

mutually beneficial goals, rather than a competitive one

- Teams and individuals take time to regularly review their objectives, performance and work processes and consider how they can be improved
- Teams, shifts, departments conduct regular after-action reviews
- Shifts, surgeries and other 'action-team' events have regular after-action reviews that collate data to share team learning.

Skills, capabilities, systems and processes for innovation

- Leaders encourage and provide practical support and rewards for innovation
- Leaders ensure that all staff, teams and leaders see quality improvement and innovation as a core part of their roles
- Proposals for innovation rarely meet barriers such as bureaucratic blockages, lack of necessary resources, criticism or censure
- Structured systems encourage and support staff to implement innovation
- Staff focus on continually improving patient care or improving performance in their functional areas (such as finance, HR or estates)
- Reflective practice and learning are widespread, and all staff are accountable for their performance
- Staff at all levels are enabled to learn about best practice from other organisations.
- There are effective improvement methodologies to promote responsible, safe innovation, such as Lean or Model for Improvement
- Quality improvement and innovation are recognised and rewarded at every level and in every department, team and function
- Staff are offered effective training, including on-the-job training, in continuous improvement methodologies
- There are effective processes for investigating unexpected or undesired events and identifying opportunities for improvement
- The organisation has sophisticated and extensive systems for collating and presenting data on performance and for benchmarking its performance against other organisations
- There are clear and simple processes for staff proposing innovations and seeking support or funding to pursue them
- There are rigorous processes for evaluating the progress of innovation projects and objectively assessing whether to continue or halt funding.

Support and autonomy

- Leaders offer inspiration and articulate a compelling vision for the future
- Leaders create positive emotional environments characterised by optimism, gratitude, appreciation and humour
- The chief executive has a personality that inspires and fosters innovation and experimentation within safe boundaries
- There is a stable senior leadership team with diverse membership and high levels of senior-team reflexivity
- Collective leadership is well-developed, with everyone taking responsibility for leadership regardless of hierarchical position. There is shared leadership in teams, leaders working interdependently across the organisation, and a shared and consistent approach to leadership that is supportive and embodies listening, enabling and facilitating staff
- There are support systems (such as Schwarz Rounds) for staff facing traumatic experiences

- There are high levels of employee engagement in every part of the organisation, and action is taken to raise levels of engagement in weak areas
- There are high levels of perceived justice and low levels of discrimination
- The structure is relatively non-hierarchical at a number of levels
- There are lower levels of formalisation and bureaucracy
- Appropriate HR practices encourage innovation.

If an NHS organisation truly aspires to meet the challenges it faces, it must draw on the deep knowledge base relating to innovation and improvement.

It must then begin the process of transforming strategies, visions and objectives, cultures and leadership, diversity and participation, systems, processes, structures and resources to support innovation. Fundamentally, this requires compassionate leadership – at every level.

References

Aime F, Humphrey S, DeRue DS, Paul JB (2014) The riddle of heterarchy: power transitions in cross-functional teams. *Academy of Management Journal* 57 (2): 327–352

Amabile TA, Khaire M (2008) Creativity and the role of the leader. Boston, Harvard Business School Publishing

Berwick D (2013) A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health, London

Bledow R, Rosing K, Frese M (2013) A dynamic perspective on affect and creativity. *Academy of Management Journal* 56 (2): 432–50

Carson JB, Tesluk PE Marrone J (2007) Shared leadership in teams: an investigation of antecedent conditions and performance. *Academy of Management Journal* 50 (5): 1217–34

Carter AJW, West MA (1999) Sharing the burden: teamwork in health care settings In Firth-Cozens J, Payne R (eds) Stress in health professionals: psychological causes and interventions. Wiley, Chichester: 191–202

Dawson JF, West MA, Admasachew L, Topakas A (2011) NHS staff management and health service quality: results from the NHS Staff Survey and related data. Department of Health, London. Available at: www.dh.gov.uk/health/2011/08/nhs-staff-management/ (accessed 21 March 2017)

De Dreu CKW (1997) Productive conflict: the importance of conflict management and conflict issue. In De Dreu CKW and Van De Vliert E (eds) Using conflict in organisations. Sage Publications, London: 9–22

Dixon-Woods M, Baker R, Charles K, Dawson J, Jerzembek G, Martin G, McCarthy I, McKee L, Minion J, Ozieranski P, Willars J, Wilkie P, West M (2013) Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study. *British Medical Journal Quality and Safety* 23: 106–115

Edmondson A (1999) Psychological safety and learning behavior in work teams. *Administrative Science Quarterly* 44 (2): 350–83

Ferlie E, Fitzgerald L, McGivern G, Dopson S, Exworthy M (2010) Networks in health care: a comparative study of their management, impact and performance. The Stationery Office, London

Ham C (2014) *Reforming the NHS from within: beyond hierarchy, inspection and markets.* The King's Fund, London. Available at: www.kingsfund.org.uk/time-to-think-differently/publications/reforming-nhs-within (accessed 21 March 2017)

Hirst G, Van Knippenberg D, Chen CH, Sacramento CA (2011) How does bureaucracy impact individual creativity? A cross-level investigation of team contextual influences on goal orientation–creativity relationships. *Academy of Management Journal* 54 (3): 624–41

Hoffman LR, Maier N (1961) Quality and acceptance of problem solutions by members of homogeneous and heterogeneous groups. *The Journal of Abnormal and Social Psychology* 62 (2): 401–7

Huerta TR, Casebeer A, Vanderplaat M (2006) Using networks to enhance health services delivery: perspectives, paradoxes and propositions. *Healthcare Papers 7* (2): 10–26

Hulks S, Walsh N, Powell M, Ham C, Alderwick H (2017) Leading across the health and care system. Lessons from experience. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/leading-across-health-and-care-system (accessed 4 August 2017)

Lemieux-Charles L, Chambers LW, Cockerill R, Jaglal S, Brazil K, Cohen C, LeClair K, Dalziel B, Schulman B (2005) Evaluating the effectiveness of community-based dementia care networks: the dementia care networks' study. *The Gerontologist* 45 (4): 456–64

Liu D, Chen XP, Yao X (2011) From autonomy to creativity: a multilevel investigation of the mediating role of harmonious passion. *Journal of Applied Psychology* 96 (2): 294–309

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas S, Tannembaum I, Cohen D, Latham G (eds) Developing and enhancing teamwork in organisations. Jossey Bass, San Francisco, CA: 331–72

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organisations. *European Journal of Work and Organisational Psychology* 24 (6): 929–50

Mickan SM, Rodger SA (2005) Effective health care teams: a model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care* 1 (4): 358–70

Milliken FJ, Martins LL (1996) Searching for common threads: understanding the multiple effects of diversity in organisational groups. *Academy of Management Review* 21 (2): 402–33

Mumford MD, Licuanan B (2004) Leading for innovation: conclusions, issues, and directions. *The leadership quarterly* 15 (1): 163–171

Paulus P (2000) Groups, teams, and creativity: the creative potential of idea-generating groups. *Applied Psychology* 49 (2): 237–62

Pearce III JA, Ravlin EC (1987) The design and activation of self-regulating work groups. *Human Relations* 40 (11): 751–82

Porac JF, Thomas H (1990) Taxonomic mental models in competitor definition. Academy of Management Review 15 (2): 224–40

Richter AW, West MA, Van Dick R, Dawson JF (2006) Boundary spanners' identification, intergroup contact, and effective intergroup relations. *Academy of Management Journal* 49 (6): 1252–1269

Sacramento CA, Sophie Chang MW, West MA (2006) Team innovation through collaboration. In Beyerlein MM, Beyerlein ST, Kennedy FA (eds) Innovation through collaboration. Emerald Group Publishing, Bingley: 81–112

Schippers MC, West MA, Dawson JF (2015) Team reflexivity and innovation: the moderating role of team context. *Journal of Management* 41 (3): 769–788

Schneider B, González-Romá V, Ostroff C, West M (2017) Organisational climate and culture: reflections on the history of the constructs. *Journal of Applied Psychology* 102 (3): 468–482

Simons T, Pelled LH, Smith KA (1999) Making use of difference: diversity, debate, and decision comprehensiveness in top management teams. *Academy of Management Journal* 42 (6): 662–73

Somech A (2006) The effects of leadership style and team process on performance and innovation in functionally heterogeneous teams. *Journal of Management* 32 (1): 132–157

Tjosvold D (1985) Implications of controversy research for management. *Journal of Management* 11 (3): 21–37

Tjosvold D (1991) Team organization: an enduring competitive advantage. Wiley, Chichester

Tjosvold D (1998) Cooperative and competitive goal approach to conflict: accomplishments and challenges. *Applied Psychology* 47 (3): 285–313

Wall TD, Bolden RI, Borrill CS, Carter AJ, Golya DA, Hardy GE, Haynes CE, Rick JE, Shapiro DA, West MA (1997) Minor psychiatric disorder in NHS trust staff: occupational and gender differences. *The British Journal of Psychiatry* 171 (6): 519–23

West MA (2012) Effective teamwork: practical lessons from organisational research. Third edition. Blackwell Publishing, Oxford

West MA (2013) Creating a culture of high-quality care in health services. *Global Economics and Management Review* 18 (2): 40–44

West MA, Borrill CS, Dawson JF, Brodbeck F, Shapiro DA, Haward B (2003) Leadership clarity and team innovation in health care. *The Leadership Quarterly* 14 (4): 393–410

West MA, Collins B, Eckert G, Chowla R (2017) Caring to change: how compassionate leadership can stimulate innovation. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/caring-change

West MA, Lyubovnikova J (2012) Real teams or pseudo teams? The changing landscape needs a better map. *Industrial and Organizational Psychology* 5 (1): 25–28

West MA, Lyubovnikova J, Eckert R, Denis, JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1: 240–260

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA, Richter AW (2007) Climates and cultures for innovation and creativity at work. In Ford C (ed) Handbook of organizational creativity. Taylor and Francis, London: 211–237

Wong CA, Cummings GG (2007) The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* 15 (5): 508–521

Worline M, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler Publishers, Oakland, CA

This summary draws on West MA, Eckert G, Collins B, Chowla R (2017) Caring to change: how compassionate leadership can stimulate innovation. The King's Fund, London. With thanks to the authors.

Further reading

Greenhalgh T, Robert G, Bate P, Macfarlane F, Kyriakidou O (eds),(2005) Diffusion of Innovations in Health Service Organisations: A Systematic Literature Review. Balckwell Publishing, Oxford

Leading for innovation

Innovation plays a vital role in modern healthcare, but instilling a culture open to innovation is complex. To succeed, leaders must understand how to create the right conditions for innovation, quality improvement and radical change.

What is it?

Leaders must understand how to lead for innovation if health and care organisations are to continually develop new and improved ways of delivering services. Leading for innovation focuses on the key knowledge, skills, abilities and behaviours that ensure high levels of innovation in teams and organisations.

Why is it important?

For the NHS to meet the challenges it faces, we must create conditions that encourage teams from top to bottom and end to end to develop and implement new and improved ways of doing things (West 2002, West and Richter 2007, West et al 2004, 2017). So all leaders, from those in national bodies to frontline supervisors, must understand how to lead for innovation. Quality improvement programmes are vital too. But if they are not to flounder, they must be implemented in the context of leadership that facilitates new and improved ways of doing things (Amabile et al 1996, Amabile and Khaire 2008).

Despite these efforts, examples of radical and sustained innovation are exceptions in the NHS. A large percentage of NHS staff (about 40%) every year say they are unable to make change happen in their area of work. This is why system transformation planning is intended to achieve the integrated, coherent and potent changes the system requires.

Find out more

NHS Staff Surveys www.nhsstaffsurveys.com/Page/1006/Latest-Results/2016-Results/

NHS England STPs www.england.nhs.uk/stps/

However, there are examples offering hope and direction from local systems that have triumphed over adversity through whole-system redesign, radically rethinking organisational roles, empowering teams to innovate, and persistently nurturing continuous improvement. Enabling leadership and cultures is essential for ensuring this innovation spreads and becomes a cultural norm in the NHS.

System leaders must understand the key contextual factors, within organisations and across systems, which create the right conditions for innovation, quality improvement, radical change and proactive action to succeed.

If leaders can make organisations and systems conducive to innovation generally, and to quality improvement specifically, their attempts to meet the challenges of modern healthcare are more likely to succeed. Leadership is central to this, and compassionate leadership is the most fundamental enabling factor that will create cultures of improvement and radical innovation across health and social care (West and Chowla 2017, Worline and Dutton 2017).

What is the evidence?

Research on high quality care cultures, cultures of innovation in healthcare and compassionate leadership reveal powerful synchronicity between the three. This argues for the potency of developing compassionate leadership for high quality and innovative cultures in healthcare.

Compassionate leadership creates the necessary conditions for innovation among individuals, in teams, in the process of inter-team working, at the level of organisational functioning as a whole and in cross-boundary or systems working.

Compassionate leadership and innovation from individual to system level

Level	Compassionate leadership activities	Cognitive/ emotional outcomes	Outcomes
Individual	• Listening • Role modelling Reflexivity • Coaching	• Self-efficacy • Self-worth at work • Good relationships	• Suggesting • Noticing opportunities • Trying, failing, learning
Team	• Creating a psychologically safe environment • Discovering meaningful differences and similarities • Facilitating purpose	• Psychological safety • Appreciating each other • Team identification	• Discussion • Review and implement • Team efficacy and potency
Inter-team	• Empathic information exchange • Role-modelling perspective taking • Awareness-building of mutual needs and interdependence	• Multi-level perspectives • Organisational identification • Diversity matters	• Lower inter-team conflict • Higher inter-team collaboration • Higher (quantity and quality) innovation

Level	Compassionate leadership activities	Cognitive/ emotional outcomes	Outcomes
Organisational	• Realistic visioning • Orchestrating belonging • Personalising purpose • Strategy as practice/ learning process	• High levels of inclusion • Secure attachment/ high organisational identification	• Organisational agility and responsiveness • Organisational resilience • Faster adoption of innovation
System-wide	• Showcasing compassionate leadership practice • Strategy as a reflective learning process	• Embracing failure as human and opportunity for improvement • Emotional resilience • Adopting a learning perspective	• System-wide learning • Robustness/resilience • Faster diffusion of innovation

Compassionate leadership and innovation

Compassionate leadership plays a powerful role in developing a culture of innovation. It comprises four behaviours:

- attending
- understanding
- empathising
- helping.

We describe each below in the context of leading for innovation. To see more about compassionate leadership [provide xrefs eg to 3–03].

Attending

Attention is vital for innovation for two reasons. First, it ensures the key challenges facing staff are identified (a prerequisite for innovation). Second, it ensures the leader is aware of the domains within which innovation and improvement are required (Van de Ven 1986, Van de Ven and Poole 1995, Van de Ven et al 2008).

When leaders pay attention to accounts of difficulties, challenges and problems, this focuses their awareness or organisational attention on problems and challenges. These can then be explored in depth. This is the most important phase of the innovation process because a good understanding of the issues ensures that innovation attempts are appropriately directed. Leaders who actively listen pay attention, withhold judgement, clarify, summarise, reflect and share.

Understanding
Compassionate leaders work alongside staff to make sense of and understand the challenges they face. A collective, compassionate approach to leadership is engaging and supportive, rather than hierarchical and directive. The more staff are enabled, supported and empowered to develop a comprehensive understanding of the challenges they face, the more likely they are to develop effective innovations in response because they have an expert perspective. Leaders who use coaching behaviours help others discover solutions for their problems themselves, enhance their self-discovery, and increase their self-awareness and self-efficacy (Ting and Scisco 2012, Strauss et al 2009).

Empathising
Empathic leadership increases team members' motivation, commitment and engagement – vital for innovation at every level of organisations. Empathy also creates a more positive emotional environment. This is associated with higher levels of creativity and innovation and enables 'affective shift' (where negative emotion is transformed into positive emotion with the by-product of creativity – Bledow 2013). For example, after a negative event, people who are give time and support to reflect with others are more likely to focus on and celebrate their compassionate response, rather than remain fixated on the traumatic elements.

As a consequence, they are more likely to notice opportunities for compassionate and innovative responses to overcome challenges in the future. And they are more likely to make suggestions proactively, knowing their voices are listened to and their perspective is appreciated. With a more positive mood, they are likely to have greater resilience and to learn from mistakes and failure (Fredrickson 2004).

In addition, the more a leader can empathise with their staff, the more motivated staff will be to help solve the challenges they face (Batson et al 1995, Brown et al 2003, Worthington and Scherer 2004). Compassion creates a sense of being valued at work (Dutton and 2014), and feeling valued, respected, understood and supported by leaders is associated with higher levels of engagement and innovation (West and Richter 2007).

Helping
The fourth component of compassionate leadership involves leaders taking thoughtful and intelligent action to support staff in their work. This includes the innovation stages of ideation, selection, implementation and evaluation. Compassionate leadership involves helping staff develop ideas for new and improved ways of doing things, whether delivering healthcare, completing administrative tasks, supporting patients and their families or overseeing financial probity.

This form of leadership also helps staff to evaluate options in a non-threatening environment where leaders do not impose or reject solutions because of their hierarchical position. Compassionate leadership manifests in leaders finding the time and resources for innovation and removing the obstacles to implementing new and improved ways of working.

How leaders behave affects not just the individuals they interact with. The affective states of individual group members can influence the whole team's general mood – a phenomenon known as mood linkage or emotional contagion (Hatfield et al 1992, Totterdell 2000, Totterdell et al 1998).

Research shows that positive leader affect is associated with more positive emotion among employees (Cherulnik et al 2001), enhanced team performance (George 1995) and higher rates of positive, helpful behaviours (George 1990). Positive emotion, in turn, is associated with higher levels of creativity and innovation (Amabile et al 2005, Isen and Baron 1991).

So beyond its impact on individuals, compassion spirals out, directing caring and supportive behaviours towards others (Lilius et al 2011). This 'compassion contagion' replenishes the emotional

resources that care-givers need and cushions against stress and burnout (Lilius et al 2011, Dutton et al 2014). The positive ripples of compassion can also encourage people to act more for the common good (Lilius et al 2011, Dutton et al 2014). And all this, in turn, affects both the motivation and capacity for developing new and improved ways of delivering healthcare.

'Compassion' also implies a collective approach to leadership: leadership of all, by all, for all. This means everyone taking responsibility for (West et al 2014):

- ensuring care is high quality, continually improving and compassionate
- shared, rather than dominating, leadership in teams
- interdependent leadership, with leaders working together across boundaries prioritising patient care overall – not just in their own area of responsibility
- consistent approaches to leadership across organisations characterised by authenticity, openness, curiosity, kindness, appreciation – and, above all, by compassion.

Collective leadership creates the culture for high quality, compassionate care. This is because all staff accept that leadership power is distributed to wherever expertise, capability and motivation sit within the organisation. That, in turn, stimulates individual, team and cross-boundary innovation.

How is it done?

Above all, leading for innovation requires leaders to lead with compassion (attending, understanding, empathising and helping).

It also requires a focus on four key areas:

- vision and strategy
- inclusion and participation
- team and cross-boundary working
- autonomy and support.

We explain these below.

Inspiring vision and strategy

Fundamentally, all leaders must demonstrate an unwavering focus on the vision and strategy for providing high quality, continually improving and compassionate care. They must nurture optimism and a sense of efficacy about progress towards this goal (Dixon-Woods et al 2013, Schneider et al 2017). Such clarity of vision and strategy in practice – as opposed to mere rhetoric – is associated with higher levels and quality of innovation and improvement (West and Richter 2007).

Compassionate, skilled leadership means translating visions and strategies into a limited number of challenging but manageable priorities with clear, aligned and challenging objectives for all teams at all levels in the organisation (West 2013). These conditions also facilitate innovation. Compassionate leaders agree rather than impose objectives, based on a shared understanding of the team's work context.

Compassionate leadership also addresses the problem of work overload. This damages employees' health and inhibits effective innovation. This means ensuring that the workload with the resources available. Teams that have agreed a limited number (five or six) of challenging, clear and motivating objectives are more effective and innovative than other teams without this clarity of direction (West 2012).

Positive inclusion and participation

Compassionate leadership is inclusive. It ensures all voices are heard in the process of delivering and improving care. Compassionate leadership creates psychological safety and encourages team members to:

- pay attention ('listen with fascination' to each other)
- develop mutual understanding
- empathise
- support each other (West and Markiewicz 2016).

Such psychologically 'safe' team environments enjoy higher levels of learning and innovation (Edmondson 1999). Leaders' empathic responses, which mirror people's emotions, create the sense of psychological safety that Edmondson and others have shown is vital for developing innovation in healthcare teams – what she calls 'learning when it's safe'.

Leaders must value diversity because it adds to the total pool of task-related skills, information and perspectives. Compassionate leadership is associated with valuing all voices in teams. This results in effective decision-making, high quality work and innovation (De Dreu 1997, Hoffman and Maier 1961, Pearce and Ravlin 1987, Paulus 2000, Porac and Howard 1990, Tjosvold 1985, 1991, 1998).

This is why compassionate, collective and inclusive leadership – which promotes positive attitudes to diversity, inclusion, creativity and innovation – must be replicated in every team and department, and at every level of the organisation. This leadership will also involve patient groups and the wider community. Service user voices are powerful stimulants to innovation, with extensive patient and carer involvement associated with higher levels of innovation and improvement (West and Richter 2007).

Enthusiastic team and cross-boundary working

Good team leadership ensures connection and compassion across boundaries, so that healthcare staff work together across professions to deliver high quality care (West and Lyubovnikova 2012, West and 2012). Compassionate leadership of teams involves ensuring a climate that encourages listening carefully to others, understanding all perspectives in the team, empathy and social support, and supporting one another. These are precisely the conditions for team innovation (Sacramento et al 2006), and teams that practise these simple teamworking skills are considerably more innovative than others.

In healthcare, supportive teams, with compassionate team leadership, have significantly lower levels of stress than dysfunctional or 'pseudo' teams (teams without clear objectives, interdependent working and/or reviewing processes). The more staff work in teams of this type, the lower the levels of stress, errors, staff injuries, harassment, bullying and violence against staff, staff absenteeism and (in the acute sector) patient mortality (Carter and West 1999, Lyubovnikova and West 2013, Lyubovnikova et al 2015, West and Markiewicz 2016). Teams with these characteristics ensure greater role clarity for their members, provide more social support and buffer members from the negative and depleting effects of wider organisational pressures. All of these are conditions for innovation (Sacramento et al 2006).

In modern healthcare, leaders must ensure that a core objective of any team is to demonstrate enthusiastic cross-boundary co-operation so that it becomes the norm (Richter et al 2006). This is particularly important in developing sustainability and transformation partnerships and vanguards in the NHS, as well as place-based systems of care. Understanding how to implement these approaches is vital, but the challenges associated with them offer a huge opportunity to develop innovation – particularly radical innovation.

Leaders must encourage their teams to adopt a mindset that holds that each team has equal relevance and value. Their perspective on the organisation expands to include other teams' needs, their value in achieving the organisation's goals and their interdependence with each other. This mindset leads staff to identify with their own team as well as with the organisation at large. This leads to lower inter-group conflict and higher inter-team collaboration. Overall, it is one of the most powerful levers to increase the quantity and quality of organisational innovation (Richter et al 2006).

Health and social care services must be integrated to meet the needs of patients, service users and communities efficiently and effectively (Ferlie et al 2010, Huerta et al 2006, Lemieux-Charles et al 2005). This requires leaders to work together, spanning boundaries within and between organisations, prioritising overall patient care rather than just the success of their part of the system.

That means leaders working collectively to build a co-operative, integrative leadership culture – in effect, collective leadership at the system level. This requires:

- a shared vision of high quality, compassionate and continually improving care
- frequent and supportive contact across boundaries between leaders
- a long-term commitment to co-operative working
- quick, creative and fair conflict resolution
- orientation towards helping the other.

All these elements of cross-boundary working are fundamentally underpinned by compassion.

Support and autonomy

To create the conditions for innovation, leaders must ensure their teams have the encouragement and autonomy to experiment, discover and apply new and improved ways of delivering care (Liu et al 2011, Somech 2006).

Releasing the capacity for innovation is more likely when staff are supported and given discretion, control and freedom for service improvement (Hirst et al 2011). When leaders make sure staff are freed to decide their work methods, scheduling, time management and objectives, those staff introduce significantly more new and improved ways of doing things in their work.

Similarly, teams that report high levels of autonomy generate a high quantity and quality of ideas for new and improved ways of doing things, and implement more high quality innovations in practice, measured as magnitude, radicalness, novelty and effectiveness (West and Anderson 1996, West 2002, West et al 2004).

Tips

- Compassionate leadership is the opposite of hierarchical, directive leadership. The two styles do not co-exist.
- The more directive the leadership, the lower the levels of innovation.
- The conditions for innovation are created through caring for those we lead, serving them, helping them grow and develop, and giving them the freedom to explore and experiment within safe boundaries.
- Leaders who encourage shared team leadership create the conditions where staff are more likely to challenge the status quo.
- Compassionate leadership will encourage staff to be innovative within safe boundaries.
- Directive, brusque managers dilute people's ability to innovate and to make good decisions.
- These leaders will deplete the emotional resources of staff and hinder their ability to relate effectively to patients – especially those who are distressed or present with behaviour that challenges.

References

Amabile TA, Khaire M (2008) Creativity and the role of the leader. Harvard Business School Publishing, Boston

Amabile TM, Barsade SG, Mueller JS, Staw BM (2005). Affect and creativity at work. Administrative Science Quarterly 50 (3): 367–40.

Amabile TM, Conti R, Coon H, Lazenby J, Herron M (1996). Assessing the work environment for creativity. *Academy of Management Journal* 39 (5): 1154–1184

Batson CD, Turk CL, Shaw LL, Klein TR (1995) Information function of empathic emotion: Learning that we value the other's welfare. *Journal of Personality and Social Psychology* 68 (2): 300–313

Bledow R, Rosing K, Frese M (2013) A dynamic perspective on affect and creativity *Academy of Management Journal* 56 (2): 432–50

Brown SL, Nesse RM, Vinokur AD, Smith DM (2003) Providing social support may be more beneficial than receiving it: results from a prospective study of mortality. *Psychological Science* 14 (4): 320–27

Carter AJW, West MA (1999) Sharing the burden: teamwork in health care settings. In Firth-Cozens J, Payne R (eds) Stress in health professionals: psychological causes and interventions. Wiley, Chichester: 191–202

Cherulnik PD, Donley KA, Wiewel TSR, Miller SR (2001) Charisma is contagious: the effect of leaders' charisma on observers' affect. *Journal of Applied Social Psychology* 31 (10): 2149–2159

De Dreu CKW (1997) Productive conflict: the importance of conflict management and conflict issue. In De Dreu CKW and Van De Vliert E (eds) Using conflict in organisations. Sage Publications, London: 9–22

Dutton JE, Workman KM, Hardin AE (2014) Compassion at work. *Annual Reviews of Organisational Psychology and Organisational Behaviour* 1 (1): 277–304

Edmondson A (1999) Psychological safety and learning behavior in work teams. *Administrative Science Quarterly* 44 (2): 350–383

Ferlie E, Fitzgerald L, McGivern G, Dopson S, Exworthy M (2010) Networks in health care: a comparative study of their management, impact and performance. The Stationery Office, London

Fredrickson B (2013) Love 20: How our supreme emotion affects everything we feel, think, do, and become. Hudson Street Press, New York

George JM (1990) Personality, affect, and behavior in groups. *Journal of Applied Psychology* 75 (2): 107–16

George JM (1995) Leader positive mood and group performance: the case of customer service. *Journal of Applied Social Psychology* 25 (9): 778–794

Hatfield E, Cacioppo JT, Rapson LR (1992) Primitive emotional contagion. In Clark MS (ed) Review of personality and social psychology: emotion and social behavior. Chapter 14. Sage Publications, Newbury Park, CA: 151–77

Hirst G, Van Knippenberg D, Chen CH, Sacramento CA (2011) How does bureaucracy impact individual creativity? A cross-level investigation of team contextual influences on goal orientation–creativity relationships. *Academy of Management Journal* 54 (3): 624–641

Hoffman LR, Maier N (1961) Quality and acceptance of problem solutions by members of homogeneous and heterogeneous groups. *The Journal of Abnormal and Social Psychology* 62 (2): 401–407

Huerta TR, Casebeer A, Vanderplaat M (2006) Using networks to enhance health services delivery: perspectives, paradoxes and propositions. *Healthcare Papers* 7 (2): 10–26

Isen AM, Baron RA (1991) Positive affect as a factor in organisational-behavior. *Research in Organisational Behavior* 13: 1–53

Lemieux-Charles L, Chambers LW, Cockerill R, Jaglal S, Brazil K, Cohen C, LeClair K, Dalziel B, Schulman B (2005) Evaluating the effectiveness of community-based dementia care networks: the dementia care networks' study. *The Gerontologist* 45 (4): 456–464

Lilius JM, Kanov J, Dutton JE, Worline MC, Maitlis S (2011) Compassion revealed: what we know about compassion at work (and where we need to know more). In Cameron K, Spreitzer G (eds) The Oxford handbook of positive organisational scholarship. Oxford University Press, New York, NY

Liu D, Chen XP, Yao X (2011) From autonomy to creativity: a multilevel investigation of the mediating role of harmonious passion. *Journal of Applied Psychology* 96 (2): 294–309

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas S, Tannembaum I, Cohen D, Latham G (eds) Developing and enhancing teamwork in organisations Jossey Bass, San Francisco, CA: 331–372

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organisations. *European Journal of Work and Organisational Psychology* 24 (6): 929–950

Paulus P (2000) Groups, teams, and creativity: the creative potential of idea-generating groups. *Applied Psychology* 49 (2): 237–62

Pearce III JA, Ravlin EC (1987) The design and activation of self-regulating work groups. *Human Relations* 40 (11): 751–82

Porac JF, Thomas H (1990) Taxonomic mental models in competitor definition. *Academy of Management Review* 15 (2): 224–240

Richter AW, West MA, Van Dick R, Dawson JF (2006) Boundary spanners' identification, intergroup contact, and effective intergroup relations. *Academy of Management Journal* 49 (6): 1252–1269

Sacramento CA, Sophie Chang M-W, West MA (2006) Team innovation through collaboration. In Beyerlein MM, Beyerlein ST, Kennedy FA (eds) Innovation through collaboration. Emerald Group Publishing, Bingley: 81–112

Schneider B, González-Romá V, Ostroff C, West M (2017) Organizational climate and culture: reflections on the history of the constructs. *Journal of Applied Psychology* 102 (3): 468–482

Somech A (2006) The effects of leadership style and team process on performance and innovation in functionally heterogeneous teams. *Journal of Management* 32 (1): 132–57

Strauss K, Griffin MA, Rafferty AE (2009) Proactivity directed toward the team and organization: the role of leadership, commitment and role-breadth self-efficacy. *British Journal of Management*, 20 (3): 279–291

Ting S, Scisco P (2012) The CCL handbook of coaching: a guide for the leader coach. Wiley, Chichester

Tjosvold D (1985) Implications of controversy research for management. *Journal of Management* 11 (3): 21–37

Tjosvold D (1991) Team organization: an enduring competitive advantage. Wiley, Chichester

Tjosvold D (1998) Cooperative and competitive goal approach to conflict: accomplishments and challenges. *Applied Psychology* 47 (3): 285–313

Totterdell P (2000) Catching moods and hitting runs: mood linkage and subjective performance in professional sport teams. *Journal of Applied Psychology* 85 (6): 848–859

Totterdell P, Kellett S, Teuchmann K, Briner RB (1998) Evidence of mood linkage in work groups. *Journal of Personality and Social Psychology* 74 (6): 1504–1515

Van de Ven AH (1986) Central problems in the management of innovation. *Management Science* 32 (5): 590–607

Van de Ven AH, Polley D, Garud R (2008). The innovation journey. Oxford University Press, Oxford

Van de Ven AH, Poole MS (1995) Explaining development and change in organizations. *Academy of Management Review* 20: 510–540

West MA (2002). Sparkling fountains or stagnant ponds: an integrative model of creativity and innovation implementation in work groups. *Applied Psychology: An International Review* 51 (3): 355–424

West MA (2012) Effective teamwork: practical lessons from organisational research. Third edition. Blackwell Publishing, Oxford

West MA (2013) Creating a culture of high-quality care in health services. *Global Economics and Management Review* 18 (2): 40–44

West MA, Anderson N (1996) Innovation in top management teams. Journal of Applied Psychology 81(6): 680–693

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In P Gilbert (ed) Compassion: concepts, research and applications: Routledge, Abingdon

West MA, Hirst G, Richter A, Shipton H (2004) Twelve steps to heaven: successfully managing change through developing innovative teams. *European Journal of Work and Organizational Psychology* 13 (2): 269–299

West MA, Lyubovnikova J (2012) Real teams or pseudo teams? The changing landscape needs a better map. *Industrial and Organisational Psychology* 5 (1): 25–28

West MA, Lyubovnikova J, Eckert R, Denis, JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1: 240–260

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA, Richter AW (2007) Climates and cultures for innovation and creativity at work. In Ford C (ed) Handbook of organizational creativity. Taylor and Francis, London: 211–237

Worline M, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler Publishers, Oakland, CA

Worthington EL, Scherer M (2004) Forgiveness is an emotion-focused coping strategy that can reduce health risks and promote health resilience: theory, review, and hypotheses. *Psychology and Health* 19 (3): 385–405

Further reading

NHS Improving Quality (2015). Leading transformational change: creating the culture for innovation. NHS Improving Quality, London

Recruiting for commitment to innovation and quality improvement

If the NHS is to achieve the levels of innovation and quality improvement it needs, organisations must recruit people with the skills and commitment to put these priorities first.

What is it?

Recruiting for commitment to innovation and quality improvement (QI) involves using recruitment and selection processes that seek and appoint staff who:

- value the opportunity to innovate and improve quality in the course of their work
- see their jobs as requiring innovation and QI
- are committed to working with fellow team members to develop and implement ideas for new and improved ways of doing things.

Why is it important?

Teams and individuals in the NHS must seek and develop ideas for new and improved ways of providing care and delivering services if the NHS is to meet the challenges it faces. That will require a workforce and leaders committed to innovation and QI as a way of working, not simply an occasional add-on. Recruitment for commitment to innovation and QI is therefore vital. This is recognised too in the national framework for improvement and innovation – *Developing People – Improving Care*.

Developing People – Improving Care

https://improvement.nhs.uk/resources/developing-people-improving-care/

What is the evidence?

Caring to change reviews research on innovation and shows that compassionate leadership – a core principle of *Developing People – Improving Care* – is particularly powerful in filtering the conditions for innovation (West et al 2017).

Compassion also creates psychological safety: staff feel confident in speaking out about errors, problems and uncertainties. They feel empowered and supported to develop and implement ideas for new and improved ways of delivering services. They also work more co-operatively and collaboratively in compassionate cultures, in climates characterised by cohesion, optimism and efficacy.

Compassionate leadership is an enabling condition for innovation across sectors (Amabile and Khaire 2008, Worline and Dutton 2017) and a prerequisite for sustained innovation in health and care services.

New ideas come from the motivation, thinking and experimentation of people across the organisation. One of the most important – if not the most important – contributor to individual creativity and innovation at work is the individual's confidence, or sense of efficacy in their own creative abilities (West 1997).

Lack of confidence in one's abilities makes it more likely that a challenge will become a threat, and that an individual will avoid and resist change rather than welcoming it. So low confidence and a psychologically unsafe environment inhibit creativity and innovation.

Figure 1 describes activities that can strengthen confidence in creativity and innovation. They can be used to assess how oriented people are towards innovation and quality improvement.

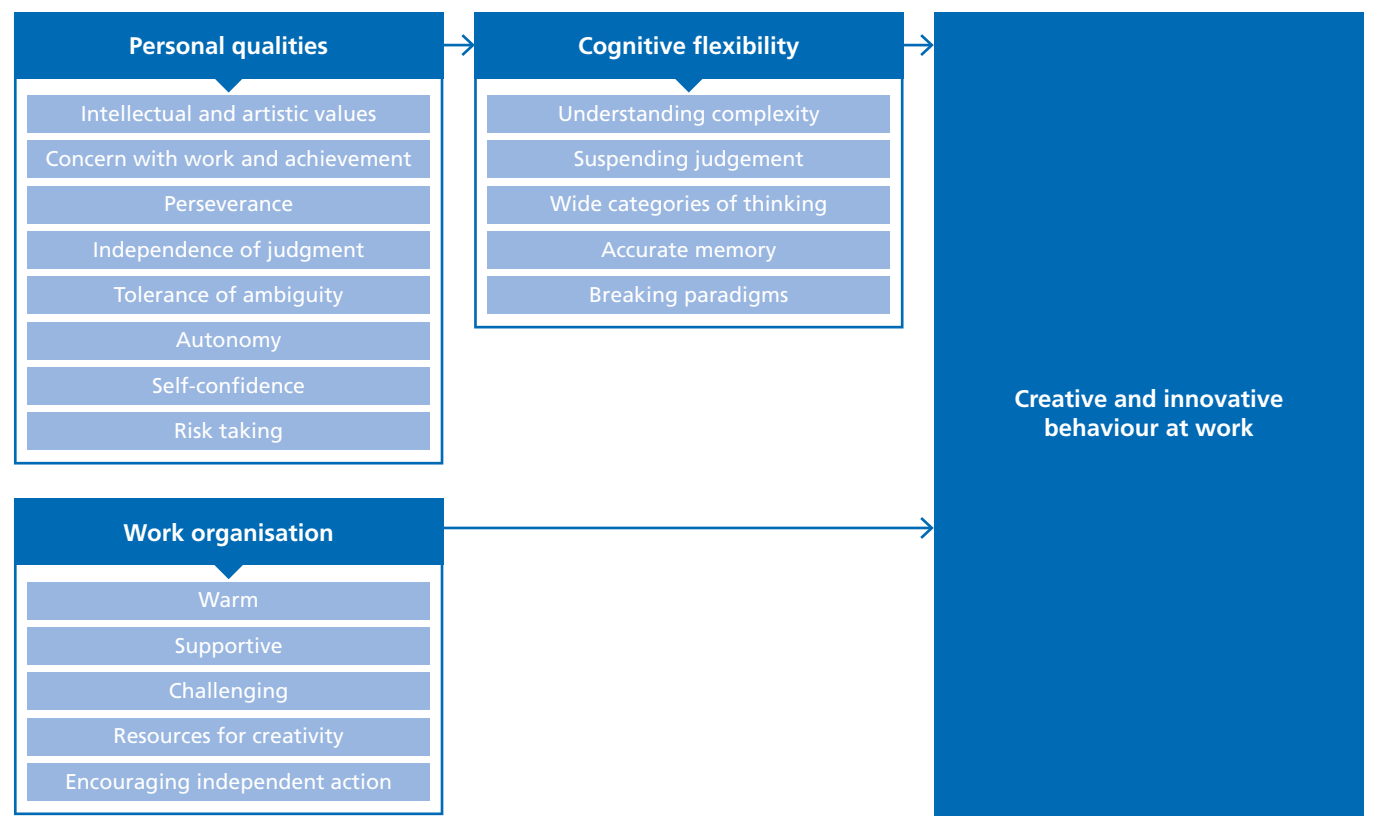


Figure 1: Characteristics of creative people and their work environments

West MA (1997) *Developing creativity in organizations*. BPS Books, Leicester

How is it done?

One way of nurturing a culture of improvement and innovation is to recruit people with personal qualities identified repeatedly in those who are consistently innovative at work (see Figure 1). These qualities include:

- attraction to complexity – interested in exploring complex, difficult issues either to understand them more fully or generate solutions
- concern with work and achievement – self-disciplined in work matters, with a high degree of drive and motivation and a concern for achieving excellence; self-motivated and deriving particular pleasure from achieving effectively in the workplace
- perseverance – determined to achieve their goals and solve problems in the workplace, often in the face of frustration and obstacles; a belief in their own strengths and skills that justifies their perseverance
- independence of judgement – coming to their own conclusions, then remaining loyal to their opinions and attitudes
- tolerance of ambiguity – responding positively to ambiguous situations, enjoying the process of sense-making
- need for autonomy – a high need for freedom, control and discretion in the workplace; often finding bureaucratic limitations or the exercise of control by managers frustrating
- self-confidence – belief in their own creativity and confident of their abilities
- orientation towards risk-taking – more prepared to take risks with new ideas and try new and improved ways of doing things, even when others are not supportive; prepared to bring about change in pursuit of improved performance and excellence at work
- intellectual and artistic values – attracted to intellectual pursuits such as high quality reading, philosophy, science and mathematics; often interested in grappling with philosophical, political and human problems; often having well-developed artistic values, including an appreciation of art, music, writing dance, literature, cinema and theatre (West 1997).

The most referenced measure of cognitive style related to innovation is Kirton's (1976) adaption-innovation scale. This distinguishes between 'adaptors,' who prefer to work within existing structures, and 'innovators,' who prefer to 'break frame'. Analyses of the scale produces three factors:

- originality
- efficiency
- conformity.

Managing conflict

Leaders of innovation and improvement must be effective at managing conflict. This is because innovation threatens the status quo, so produces conflict.

If an organisation introduces a new way of doing things and does not generate any conflict, either the innovation is not really new or it does not offer a significant contribution. You will know this is the case if there are no disagreements about the content or process of the innovation, or if it meets no resistance from organisation members.

Linked resources

Here you can find series of tools: inventories that provide useful ways of assessing people's orientations towards innovation and improvement. You will find measures of:

- propensity to innovate
- team innovation
- confidence in creativity and innovation
- assessing creativity and innovation
- potential for encouraging others' innovation and improvement
- conflict management

Tip: The Big Five model

As well as the inventories provided here, you may find it useful to look at the Big Five personality model (Barrick and Mount 1991). This includes five core personality dimensions including 'openness to experience'. This is the best predictor of creativity and innovation at work, and therefore for recruiting for innovation and quality improvement.

You can find several robust and reliable measures, including some that are free to use, at http://pages.uoregon.edu/sanjay/bigfive.html

References

Amabile TA, Khaire M (2008) Creativity and the role of the leader. *Harvard Business Review* 86 (10): 100–109

Barrick MR, Mount MK (1991) The big five personality dimensions and job performance: a meta-analysis. *Personnel Psychology* 44 (1): 1–26

Kirton, M. (1976) Adaptors and innovators: a description and measure. *Journal of Applied Psychology* 61 (5): 622

West MA (1997) Developing creativity in organizations. British Psychological Society, Leicester

West M, Eckert R, Collins B, Chowla R. (2017). Caring to change: how compassionate leadership can stimulate innovation in health care. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf (accessed 4 August 2017)

Worline M, Dutton JE (2017) Awakening compassion at work: the quiet power that elevates people and organizations. Berrett-Koehler Publishers, Oakland, CA

Measure 1: Propensity to innovate

1	I try to introduce improved methods of doing things at work	1	2	3	4	5
2	I have ideas that would significantly improve the way the job is done	1	2	3	4	5
3	If there is a problem or challenge at work, I will ignore the rules in order to find a new solution	1	2	3	4	5
4	I tend to change existing policies relating to my areas of work	1	2	3	4	5
5	I suggest new working methods to the people I work with	1	2	3	4	5
6	I try to avoid introducing 'changes for change's sake'	1	2	3	4	5
7	I tend to improve methods for solving problems when the answer is not apparent	1	2	3	4	5
8	I change the specification of what my job entails so as to improve my functioning in it	1	2	3	4	5
9	I use different methods to other individuals performing the same type of job	1	2	3	4	5
10	I look for novel approaches to dealing with my work	1	2	3	4	5
11	I contribute to changes in the way my department works	1	2	3	4	5
12	I am receptive to new ideas that I can use to improve things at work	1	2	3	4	5

Response scale

1	2	3	4	5
strongly disagree	disagree	not sure	agree	strongly agree

Measure 2: Team innovation

Compared with other similar teams, how innovative do you consider your team to be? Circle the appropriate response for the following task areas:

	Highly stable: few changes introduced		Moderately innovative: some changes introduced		Highly innovative: many changes introduced
1 Setting work targets or objectives	1	2	3	4	5
2 Deciding the methods used to achieve objectives/targets	1	2	3	4	5
3 Initiating new procedures or information systems	1	2	3	4	5
4 Developing innovative ways of accomplishing targets/ objectives	1	2	3	4	5
5 Initiating changes in the job contents and work methods of your staff	1	2	3	4	5

Total Score:

Low score	5 to 13
Average score	14 to 18
High score	19 to 25

Measure 3: Confidence in creativity and innovation

Below is a list of activities that can help generate confidence and boost creativity and innovation. Consider the list carefully and indicate how frequently you engage in each of the following activities:

		Almost never	Infrequently	Moderately often	Very frequently	All of the time
1	Relax in dealing with problems	1	2	3	4	5
2	Let one answer lead to another	1	2	3	4	5
3	Break away from the obvious, the commonplace	1	2	3	4	5
4	Defer judgements of my own ideas	1	2	3	4	5
5	Generate multiple solutions	1	2	3	4	5
6	Give myself time to consider problems	1	2	3	4	5
7	Trust my own wisdom	1	2	3	4	5
8	Reject negative self-statements (for example, 'I can't do it')	1	2	3	4	5
9	Give myself space to create ideas	1	2	3	4	5
10	Take relaxation breaks – go for walks and get fresh air	1	2	3	4	5
11	Get away from interruptions	1	2	3	4	5
12	Use humour to ease tension and generate ideas	1	2	3	4	5
13	Build confidence by seeking out information	1	2	3	4	5
14	Break tasks into manageable parts	1	2	3	4	5
15	Avoid working with negative people while developing ideas	1	2	3	4	5
16	Develop a self-image of being a creative and innovative person	1	2	3	4	5
17	Make the challenge fun rather than a threat	1	2	3	4	5
18	See things in new ways	1	2	3	4	5
19	Be playful	1	2	3	4	5
20	Have the courage of my convictions in the face of opposition	1	2	3	4	5

Measure 4: Assessing creativity, innovation and openness to experience

Many measures of general creativity are available, but some are particularly good:

The Torrance Test of Creative Thinking measures problem finding as well as creative problem-solving abilities, and the validity of this test has been demonstrated in a number of studies (Torrance et al 2003).

The Kirton Adaption-Inventory (KAI) is a widely used measure of creativity in management. Described as a measure of creative style rather than creative level, the questionnaire data reveal two types of people:

- 'adapters', who tend to be low on originality and high on efficiency and conformity
- 'innovators', who are high on originality and low on efficiency and conformity.

Adapters tend to extend existing practices to produce minor innovations whereas innovators tend to change structures radically to bring about change in their workplaces (Kirton 1987).

Openness to experience forms part of the Big Five personality model and is the best predictor of creativity and innovation at work, and therefore for recruiting for innovation and quality improvement. There are a number of robust and reliable measures including some free-to-use measures http://pages.uoregon.edu/sanjay/bigfive.html .

References

Kirton M (1987) Kirton adaption-innovation inventory manual. Occupational Research Centre, Hatfield

Torrance EP, Ball OE, Safter HT (2003) Torrance tests of creative thinking. Scholastic Testing Service, Bensenville, IL

Measure 5: Encouraging others' innovation and improvement

(for self-completion or by team colleagues)

Consider the following list and indicate how often you behave in ways that are supportive. Tick the category that most clearly corresponds to your work experience

How often do you...	Almost never	Very infrequently	Neither frequently nor infrequently	Very frequently	Almost always
Find value in ideas rather than criticise them	○	○	○	○	○
Eliminate status	○	○	○	○	○
Make boring tasks interesting or challenging	○	○	○	○	○
Take relaxation breaks	○	○	○	○	○
Give space to creative ideas	○	○	○	○	○
Avoid rigour too early on (do not engage in immediate criticism)	○	○	○	○	○
Are unrestrained in idea generation	○	○	○	○	○
Challenge the rules and go against convention	○	○	○	○	○
Challenge organisational constraints	○	○	○	○	○
Say 'Yes' to others' ideas	○	○	○	○	○
Show interest, approval or support for others' ideas	○	○	○	○	○
Listen to others actively	○	○	○	○	○
Look for positive learning in others' mistakes	○	○	○	○	○
Make challenges fun	○	○	○	○	○
Introduce play and humour	○	○	○	○	○
Respect the people you work with	○	○	○	○	○
Have a positive outlook	○	○	○	○	○
Trigger ideas with others	○	○	○	○	○
Encourage an atmosphere of freedom	○	○	○	○	○
Draw on others' skills	○	○	○	○	○
Encourage freedom of discussion	○	○	○	○	○
Avoid using ridicule	○	○	○	○	○
Reward others' innovations and improvements	○	○	○	○	○

Add up the number of 'very frequently' or 'almost always' ticks. This should be more than half the number of questions. From West (1997) *Developing creativity in organizations.*

Measure 6: Conflict management

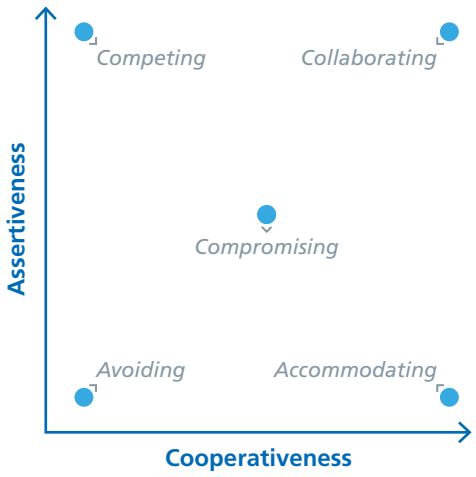
Assessing conflict management skills for leading innovation. The Thomas-Kilman measure of conflict management (TKI)

Because no two individuals have exactly the same expectations and desires, conflict is a natural part of our interactions with others. The TKI is an online assessment that takes about fifteen minutes to complete. Interpretation and feedback materials help you learn about the most appropriate uses for each conflict-handling mode.

The TKI has been the leader in conflict resolution assessment for more than forty years. This instrument requires no special qualifications for administration. It is used by Human Resources (HR) and Organizational Development (OD) consultants as a catalyst to open discussions on difficult issues and facilitate learning about how conflict-handling modes affect personal, group, and organizational dynamics. The TKI is also extensively used by mediators, negotiators, and many practitioners in the coaching profession (executive coaches, career coaches, business coaches, life coaches, etc.).

More than 8,000,000 copies of the TKI have been published since 1974. Besides its native English language, the TKI is also available in several other languges: Spanish (European and Latin American), French, Portuguese (Brazilian), Danish, Dutch, Swedish, Japanese, Russian, German, Italian, and Chinese (traditional and simplified).

The TKI is designed to measure a person's behavior in conflict situations. "Conflict situations" are those in which the concerns of two people appear to be incompatible. In such situations, we can describe an individual's behavior along two dimensions: (1) assertiveness, the extent to which the person attempts to satisfy his own concerns, and (2) cooperativeness, the extent to which the person attempts to satisfy the other person's concerns.



These two basic dimensions of behaviour define five different modes for responding to conflict situations:

1. Competing is assertive and uncooperative – an individual pursues his own concerns at the other person's expense. This is a power-oriented mode in which you use whatever power seems appropriate to win your own position – your ability to argue, your rank, or economic sanctions. Competing means "standing up for your rights," defending a position which you believe is correct, or simply trying to win.
2. Accommodating is unassertive and cooperative – the complete opposite of competing. When accommodating, the individual neglects his own concerns to satisfy the concerns of the other person; there is an element of self-sacrifice in this mode. Accommodating might take the form of selfless generosity or charity, obeying another person's order when you would prefer not to, or yielding to another's point of view.
3. Avoiding is unassertive and uncooperative – the person neither pursues his own concerns nor those of the other individual. Thus he does not deal with the conflict. Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a threatening situation.
4. Collaborating is both assertive and cooperative – the complete opposite of avoiding. Collaborating involves an attempt to work with others to find some solution that fully satisfies their concerns. It means digging into an issue to pinpoint the underlying needs and wants of the two individuals. Collaborating between two persons might take the form of exploring a disagreement to learn from each other's insights or trying to find a creative solution to an interpersonal problem.
5. Compromising is moderate in both assertiveness and cooperativeness. The objective is to find some expedient, mutually acceptable solution that partially satisfies both parties. It falls intermediate between competing and accommodating. Compromising gives up more than competing but less than accommodating. Likewise, it addresses an issue more directly than avoiding, but does not explore it in as much depth as collaborating. In some situations, compromising might mean splitting the difference between the two positions, exchanging concessions, or seeking a quick middle-ground solution.

Each of us is capable of using all five conflict-handling modes. None of us can be characterized as having a single style of dealing with conflict. But certain people use some modes better than others and, therefore, tend to rely on those modes more heavily than others—whether because of temperament or practice.

Your conflict behavior in the workplace is therefore a result of both your personal predispositions and the requirements of the situation in which you find yourself. The TKI is designed to measure this mix of conflict-handling modes.

Development for managing innovation

Managing innovation involves more than overseeing change: it means understanding why people resist change and making sure individuals and teams work in a culture of inspiration and trust, so they can perform at their best and implement their ideas for innovation and quality improvement.

What is it?

Development for managing innovation and change involves understanding the innovation process, team innovation and change management, and putting that understanding into practice.

Why is it important?

The NHS faces huge challenges of improving patient care. "The NHS in England cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy" (Ham et al 2016).

So all leaders and potential leaders need to understand how to manage innovation and change. Because innovation and change are so important in healthcare, understanding innovation and change processes equips people to manage them better, whether they are the leaders or the implementers of change.

What is the evidence?

Rogers (1983) and Daft (1992), among others, have shown how the innovation process fails because of poor leadership and change management processes. Considerable work on healthcare teams has demonstrated the importance of team processes in determining the extent to which teams introduce new and improved ways of doing things. Examples have included breast cancer care, community mental health, primary care and executive teams. (For a review, see Lyubovnikova and West 2013, West and Markiewicz 2016.)

When we think about how to stimulate innovation and quality improvement at work, leaders clearly have a powerful influence on the immediate social and psychological environment. If the work climate they create does not support innovation, staff who derive satisfaction from developing new and improved ways of working will become frustrated. Research has revealed that warm, supportive and flexible but intellectually demanding environments produce high levels of creativity and innovation (Amabile 1997, Amabile et al 1996).

Organisations also have to provide appropriate resources for innovation and encourage independent action to facilitate the innovativeness of those who work within them. Organisations that generate innovation have climates encouraging interaction, individual and team autonomy and new ideas. Where climates are characterised by distrust, lack of communication, limited individual autonomy and unclear goals, innovation is more likely to be inhibited (West and Richter 2007).

How is it done?

Innovation is implemented effectively when the innovator plans the management of each stage thoughtfully and realistically. So leaders and individuals must be equipped with the skills to manage the innovation process. This section highlights two approaches to the innovation process, developed by Rogers (2010) and Daft (1998) respectively.

Approach 1: Rogers (2010)

Rogers says the innovation process has two major stages: initiation and implementation, each of which has further substages.

Stage 1: Initiation

Agenda setting

This involves identifying organisational problems where there is a mismatch between the actual and desired performance of the organisation or some part of it. There may be a specific performance gap, such as dissatisfaction with the way customer complaints are managed. An innovation may address this gap, such as improved training for the patient complaints team.

Matching

In this stage, judgements are made about how likely the identified innovation is to meet the organisation's specific problem. On the basis of these judgements, the innovation process is either terminated or continued. It is a process of constructively appraising and criticising the idea, to determine its real value in meeting organisational needs.

Stage 2: Implementation

Redefining/restructuring

The innovation in question is then modified or reinvented to fit the organisation's specific requirements. Alternatively, aspects of the organisation may be altered to fit the innovation.

Clarifying

The innovation is implemented and discussed fully with staff to make sure its meaning is clear to everyone affected by it. Where misunderstandings arise about the innovation's purpose or content, further information is supplied. Where unanticipated side-effects occur, corrective action is taken.

Routinising

At this point, the innovation becomes part of the normal organisational process and is no longer identified as an innovation. It is a routine, accepted part of organisational functioning.

Rogers (2010) argues that generally, the later stages of the process cannot be successfully completed if the earlier ones have not been negotiated.

Approach 2: Daft (1992)

Daft represents the innovation process more simply, describing five stages or elements:

- Needs – a performance gap is recognised and innovative alternatives considered.
- Idea – an idea for a new and improved way of doing things is generated. The idea is then matched to the need.
- Adoption – decision-makers choose to support implementation of the proposed idea.
- Implementation – organisational members begin to use the new idea, technique or process in practice, in their work.
- Resources – the human energy and activity required to bring about the change. Daft argues that change requires time and resources to be dedicated to creating and implementing ideas, and that resources are therefore vital to innovation.

Daft believes that for a change to be successfully implemented, leaders must ensure each of the five elements occur within the organisation.

The rest of this section considers two important themes central to leading innovation and change: team innovation and managing change. Innovation is generally implemented by teams rather than individuals, and managing the implementation of innovation is about managing change (West 2002).

Team innovation

The team is the functional unit of all healthcare organisations. If an organisation is to be innovative, the teams within it must also be innovative, adaptable and essentially creative in responding to problems in the organisation and the wider environment. So leaders and team members must understand how to lead or work in teams to encourage innovation and quality improvement. In particular, team innovation involves the shared development and application of ideas that improve health and care.

Four factors determine how effective a team will be in innovating:

1. Team vision

For a team to be innovative it must have vision, to focus and direct creative energies. For example, for a primary healthcare team, this may involve enabling patients to take responsibility for their health by giving them a sense of power and control over their own physical health outcomes.

2. Team participation

Teams must be participative. Participation incorporates three fundamental concepts:

- Influence over decision-making – Team members with influence over decision-making are more likely to contribute ideas for new and improved ways of doing things. This participation ensures that the views, experience and abilities of everyone in the team are added to the pallet of ideas with which the team will paint the future.
- Information sharing – Unless team members communicate and share information openly and generously, the team can miss the opportunities to generate new ways of doing things.
- Interaction – How often team members interact will determine the extent to which they exchange ideas, information and conflicting views. Frequent interaction will enrich their collective bank of knowledge and innovation opportunities.
- Psychological safety – Innovation is about new and different things: the untried and untested, things that may fail or generate resistance and conflict. It is about taking risks. But team members are only willing to try out new ideas – and to risk appearing foolish – if they feel safe from ridicule or attack. We are more likely to offer new and different ideas if the team provides a sense of safety and support in expressing those ideas.

3. Commitment to excellence

Commitment to high quality or excellence is critically necessary to team innovation. This involves:

- Reflexivity – important in making sure team strategies, processes and task outcomes are appropriate. The more that teams take time to reflect critically on their objectives, strategies and processes – and then crucially, modify them – the more innovative and effective they are likely to be.
- Constructive controversy – present where team members feel their competence is affirmed rather than attacked, in a climate of co-operation and trust rather than competition and distrust, where critical review is seen as a constructive process rather than a destructive, aggressive conflict.
- Minority influence – the extent to which a team can tolerate differing views is an important determinant of innovation.

4. Support for innovation

This is the most significant predictor of innovation in teams. It has two distinct elements: espoused support and active support. Teams must also give time, resources and co-operation for the development of new ideas.

Managing change

Leading innovation processes involves understanding why people resist change in organisations and recognising that this resistance is not necessarily good or bad. Sometimes it is a normal and natural reaction to change. At other times, it is a reasonable reaction to an inappropriate attempt to change the status quo.

Change and conflict

Leaders of innovation and improvement must be effective at managing conflict. This is because innovation threatens the status quo, so produces conflict.

If an organisation introduces a new way of doing things and does not generate any conflict, either the innovation is not really new or it does not offer a significant contribution. You will know this is the case if there are no disagreements about the content or process of the innovation, or if it meets no resistance from organisation members.

The Thomas-Kilman measure of conflict management (TKI) assesses conflict management skills for leading innovation.

www.kilmanndiagnostics.com/overview-thomas-kilmann-conflict-mode-instrument-tki

Why people resist change

Key reasons that people resist change include (Woods and West 2015):

- Parochial self-interest – Sometimes people see change as inconvenient, and resist it because it is change, regardless of whether they perceive it as beneficial or detrimental to the organisation. They may also feel the change will somehow disrupt their own working lives.
- Vested interests – People resist change if they see it threatening their job security, power, status, pay differentials or the diversity of their jobs. When introducing an innovation, it is essential to think through how the proposed change will affect other people in the organisation, and their likely reactions.
- Misunderstanding – A frequent cause of resistance to change is misunderstanding about its nature and consequences. This often occurs when there is inadequate consultation, education and information sharing about the innovations to be introduced.
- Low tolerance of change – People often resist change simply because they have endured too much over a given period.
- The change process – Resistance to change often arises from how consultation and participation are managed. If people are involved in the innovation process, they are much less likely to resist the change.

When managing and leading innovation, it is essential to work with all those affected or who perceive they may be affected. Coalition building is vital for leading innovation and improvement.

Process 1 offers a strategy for reducing resistance to innovation, based on a combination of stakeholder and force field analysis. This tool helps develop an overview of how much resistance to innovation is likely and where major problems may arise. It enables strategic planning for managing resistance to change and participation processes.

Comparing the resulting force fields may produce useful insights into the current organisational situation. This force field analysis model was developed by Kurt Lewin (1946), who described all situations as in a "temporary equilibrium held in place by two sets of forces: driving forces which push change along and restraining forces which

pull back against change". Understanding those forces will help the innovator towards successful implementation (see, for example, Bozak 2003).

References

Amabile TM (1997) Motivating creativity in organizations: on doing what you love and loving what you do. *California Management Review* 40 (1): 39–58

Amabile TM, Conti R, Coon H, Lazenby J, Herron M (1996) Assessing the work environment for creativity. *Academy of Management Journal* 39 (5): 1154–1184

Bozak MG (2003) Using Lewin's force field analysis in implementing a nursing information system. *Computers, Informatics, Nursing* 21 (2): 80–85

Daft RL (1992) Organizational theory and design. Fourth edition. West Publishing, New York

Ham C, Berwick D, Dixon J (2016) Improving quality in the English NHS: a strategy for action. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

Lewin K (1973) Force field analysis. In Jones JE, Pfeiffer JW (eds). The 1975 Annual handbook for group facilitators. University Associates, San Diego CA

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas E, Tannembaum SI, Cohen D, Latham G (eds) Developing and enhancing teamwork in organizations. Jossey Bass, San Francisco: 331–372

Rogers EM (2010) Diffusion of innovations. Third edition. Free Press, New York

West MA (2002). Ideas are ten a penny: it's team implementation not idea generation that counts. *Applied Psychology: An International Review* 51: 411–424

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA Richter AW (2007) Climates and cultures for innovation and creativity at work. In Ford C (ed) Handbook of organizational creativity. Taylor and Francis, London: 211–237

Woods S, West MA (2014). (Second edition). The psychology of work and organizations. Sage, London

Process 1: Analysing and managing resistance to innovation

Step 1: Define the innovation you wish to implement

The outcome of the innovation will be the equilibrium you are hoping to achieve in the future, so it is important you clearly define the outcome.

Step 2: Now identify all individuals and groups that could influence your ability to introduce the innovation in your organisation

Ask each 'stakeholder' to identify major advantages and disadvantages that the introduction of the innovation may present for them.

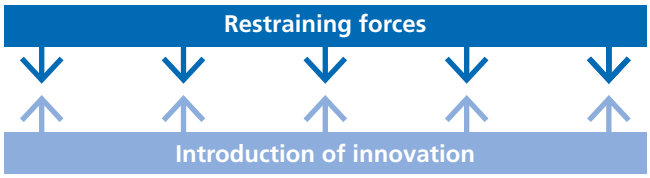
Stakeholder	Advantages	Disadvantages

Step 3: The force field

Draw a 'force field' with an arrow to represent each stakeholder. For each arrow in the force field, you will need to decide:

a. the direction of the arrow – If the arrow represents a group with mixed opinions, you must decide which side, on balance, the group as a whole will be. You may, however, indicate the situation within the arrow – for example, by patchy shading.

b. the size of the arrow – This will represent the relative power of the individual group or factor to influence the introduction of the innovation, either positively or negatively. You may wish to use colour and shading to make the arrows as representative of your view of the situation as possible.



Step 4: Action planning

After contemplating the force field you have drawn, you may have some new insights into the situation. Does the environment for introducing the innovation look more positive than you had thought? Alternatively, are the arrows more heavily weighted on the restraining side of the innovation line?

This is a good point to consider the feasibility of achieving this particular innovation at this time. With some rebalancing, the environment may well be able to support the proposed innovation. In this case, reviewing the force field will enable you to decide where you need to exert energy to either:

- decrease the power and influence of the restraining forces
- increase the power and influence of the driving forces.

Based on the analysis, what actions could you take to reduce the influence of the restraining forces and increase the power of the supporting forces? Your action plan should be helpful in determining strategies for moving forward.

Try to identify ways in which the balance of the forces can be weighted more strongly in your favour. This may be by finding new helping forces, or by trying to eliminate or lessen the effect of some of the hindering forces. People often find it easier to do the latter. To use a car analogy, it is as if one's foot is already down on the floor and there is no way to increase the driving force. The easiest solution may well be to take off the handbrake.

Leading for quality improvement

Quality improvement is crucial to the NHS's success. But individual projects are not enough to create widespread change: they must be underpinned by leadership that understands quality improvement processes and prioritises it at every level.

What is it?

Quality improvement (QI) involves designing and redesigning work processes and systems that deliver healthcare with better outcomes and lower cost (Ham et al 2016). Examples range from redesigning how teams deliver care in clinical microsystems to large-scale reconfigurations of services such as stroke or cancer care. Ham et al argue that QI must be understood, valued and enabled by the leadership.

Developing QI as a consistent and comprehensive strategy in healthcare involves:

- training leaders and staff in the nature of systems
- using statistical and quantitative data over time to understand variation
- involving all staff in contributing and acting on ideas
- a strong focus on patients' and service users' needs.

QI requires leaders to support many small-scale trials and tests of change as a way of learning, in a culture of effective teamwork and co-operation.

Why is it important?

The NHS faces a huge test to improve patient care at a time of staff shortages and unprecedented financial challenges. "The English NHS cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy" (Ham et al 2016).

Following the Mid Staffordshire inquiry, the principal recommendations in the Berwick report, A promise to learn, a commitment to act (Berwick 2013), were:

- staff focused on continually improving patient care
- staff focused on ensuring zero harm
- reflective practice and learning endemic
- all staff being accountable
- staff enabled at all levels to learn about best practice
- effective schemes to promote responsible, safe innovation (such as Lean and QI)
- recognition and reward for QI and innovation at every level and in every department, team or function.

These recommendations were designed to support NHS staff to lead improvements in care by providing education and training in quality and patient safety sciences and practices. The report made it clear that all leaders in the NHS should make quality of care and patient safety their top priorities. However, one year on, a survey found that training and support for staff in QI was the area of least progress (Health Foundation et al 2014).

According to Senge (1990), leaders are 'designers, stewards, and teachers' who have a duty to their

organisation to continually develop their own capacity – and that of the workforce – to deal with complexity. This can be achieved through a clear vision focused on learning and QI. Leadership that sparks inspiration and new ideas is important, but the real value comes from implementing these ideas in practice, to improve patient care.

So QI requires strong leadership, with a clear QI vision, using the available resources to adapt the way things are done for better patient care (Øvretveit 2009).

QI must also be seen as a collective priority, so that all the organisation's employees at all levels are empowered and encouraged to implement improvements in their roles.

What is the evidence?

Wang et al (2006) in their study of 16 US health systems found four factors critical for the success of effectively led redesign or QI initiatives:

- direct involvement of senior and middle-level managers
- clear alignment between improvement initiatives and the organisation's priorities
- formal structures, processes and performance appraisal that enable feedback, learning and continuous improvement
- development provided for 'change champions', teams and staff leading the change.

We explain each of these in turn.

Involving senior and middle-level managers

Berwick (1996: 619) argued that "effective leaders challenge the status quo both by insisting that the current system cannot remain and by offering clear ideas about superior alternatives".

So the board and senior leaders need to be involved and invest in QI, making sufficient resources available to deliver the initiatives (Bagnal 2012). It is critical that senior and middle-level managers are engaged in improvement. This helps create a learning-oriented culture. Staff will look to senior leaders or middle-level managers as role models. If they, in their position of authority, do not demonstrate a commitment to improvement, this is likely to compromise a culture of learning.

Clearly aligning improvement initiatives with the organisation's direction

Work by NHS Scotland (Scottish Government 2010) points to the importance of linking individual improvement projects with the organisation's overall strategy and vision. Communicating clearly the nature of the improvement initiative, the overall aims, and how success will be measured are also important.

Establishing formal structures and processes that enable feedback, learning and continuous improvement

Having continuous improvement systems that monitor, evaluate and evolve processes is vital (Morton 2014). However, it is important not to introduce new processes or systems to the detriment of innovation. It is also important to make sure new systems do not contribute to an overdose of overlapping, overwhelming objectives – or nurturing 'priority thickets' (West et al 2014).

The Institute for Health Improvement (IHI) points to key principles that help improvement initiatives 'stick' (Mate et al 2017). Among these is providing timely and measurable feedback for all stakeholders in the improvement work. This helps them understand their progress and be commended for their individual contributions.

Providing development for change champions, teams and all staff, for quality improvement

Finally, but perhaps most importantly, appropriate developmental support is vital for leaders, teams and staff driving improvement. While leadership in non-clinical roles is important, clinical leadership

is considered a crucial factor and a driving force to tackle QI at all levels of the system (Hardacre et al 2010, Bassett and Westmore 2012). All teams, leaders and staff should be trained in QI methods and urged to implement their learning continuously on QI projects.

How is it done?

Developing improvement capability must be a core competency for leaders across the organisation. This also requires cultures that value quality and safety of care, where leaders work together to improve care. Ham et al (2016) say that leading QI in health and care organisations requires:

- continual reduction of fear in the workforce and total engagement in the design and redesign of work and processes (as at Bellin Health, US); there must be specific and quantified goals for improving care, linked to a compelling vision of the future (as in Salford Royal's ambition to be the safest hospital in England)
- systematic, transparent measurement and reporting of progress in delivering these goals (as in Jönköping County Council, Sweden)
- use of an established QI method, supported by training all staff and all leaders in it (as in the Virginia Mason Production System and the advanced training programme at Intermountain Healthcare, US)
- clinical leadership, teamwork and engagement at all levels together with high quality management support (as in Kaiser Permanente, US)
- boards and senior leaders who accept personal responsibility for quality and safety and themselves develop deep expertise in QI (as in Wrightington, Wigan and Leigh NHS Foundation Trust and East London NHS Foundation Trust)
- commitment to listening to and learning from the experiences of patients and carers and assuring their full participation in design, redesign, assessment and governance (as in the Cleveland Clinic and Cincinnati Children's Hospital Medical Center, US).

Leading QI means designing the production or service delivery system to reduce error and waste (Orsini 2013). So all leaders need to understand and value what QI offers to the broad vision of ensuring high quality and continually improving care: clinically effective care, safe care and compassionate care.

IHI's work on high impact leadership describes the learning from those who have led successful improvement efforts (Swensen et al 2013). It recommends that these high impact leaders work with experienced managers and clinicians trained in improvement methods, supported by technical experts such as system engineers.

The technical staff use their expertise in improvement science to strengthen the operations of healthcare organisations – for example, by reducing delays and improving the flow of patients and information between staff delivering care (Ham et al 2016, President's Council of Advisors on Science and Technology 2014).

Dixon-Woods et al (2012) evaluated a wide range of Health Foundation QI programmes and summarised their findings into 10 top challenges for leading improvement (see Table 1). The challenges cover issues ranging from planning interventions, leadership and culture to external factors such as context, side-effects and unintended consequences of change.

How to address 10 challenges in improvement

Design and planning of improvement interventions

Challenge 1: Convince people that there's a problem

Use hard data and secure emotional engagement by using patient stories and voices.

Challenge 2: If you do it, will it work? Convince people of the solution

Come prepared with clear facts and figures, have convincing measures of impact and be able to demonstrate your solution's advantages.

Challenge 3: Data collection and monitoring systems

This always takes much more time and energy than anyone anticipates. It is worth investing heavily in data from the outset. Assess local systems, train people and have quality assurance.

Challenge 4: 'Projectness' and ambitions

Over-ambitious goals and too much talk of 'transformation' can alienate staff if they feel the change is impossible. Instead match goals and ambitions to what is realistically achievable and focus on bringing everyone along with you. Avoid giving the impression that the improvement activity is unlikely to survive the timespan of the project.

Organisational and institutional contexts, professions and leadership

Challenge 5: Organisational context, culture and capacities

Staff may not understand the full demands of improvement when they sign up, and team instability can be disruptive. Explain requirements to people, then provide ongoing support. Make sure improvement goals align with the organisation's wider goals, so people don't feel pulled in too many directions.

Challenge 6: Tribalism and lack of staff engagement

Overcoming a perceived lack of ownership and professional or disciplinary boundaries can be difficult. Clarify who owns the problem and solution, agree roles and responsibilities at the outset, work to common goals and use shared language.

Challenge 7: Leadership

Getting leadership for QI right requires a delicate combination of describing a vision and sensitivity to others' views. 'Quieter' leadership, oriented towards inclusion, explanation and gentle persuasion, may be more effective.

Challenge 8: Incentivising participation and 'hard edges'

Relying on staff's intrinsic motivations for QI can take you a long way, especially if you provide 'carrots' in the form of incentives, but they may not always be enough. It is important to have 'harder edges' – sticks – to encourage change, but you must use them judiciously.

Beyond the intervention: sustainability, spread and unintended consequences

Challenge 9: Securing sustainability

Sustainability can be vulnerable when efforts are seen as 'projects' or when they rely on particular individuals.

Challenge 10: Side-effects of change

It is not uncommon to successfully target one issue while causing new problems elsewhere. This can make people lose faith in the project. Be vigilant about detecting unwanted consequences and be willing to learn and adapt.

(Dixon-Woods et al 2012: 4)

References

Bagnall P (2012) Facilitators and barriers to leadership and quality improvement. The King's Fund Junior Doctor Project. The King's Fund, London Available at: www.kingsfund.org.uk/sites/default/files/facilitators-barriers-leadership-quality-improvement-pippa-bagnall-leadership-review2012-paper.pdf

Bassett S, Westmore K (2012) Systems and processes that ensure high quality care. *Nursing Management* 19 (6): 18–20

Berwick DM (1996) A primer on leading the improvement of systems. *British Medical Journal* 312 (7031): 619

Berwick D (2013) A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health, London

Dixon-Woods M, McNicol S, Martin G (2012) Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. *BMJ Quality and Safety* 21: 876–884

Ham C, Berwick D, Dixon J (2016) Improving quality in the English NHS: a strategy for action. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

Hardacre J, Cragg R, Flanagan H, Spurgeon P, Shapiro J (2010) Exploring links between NHS leadership and improvement. *International Journal of Leadership in Public Services* 6 (3): 26–38

Health Foundation, Monitor, NHS Trust Development Authority (2014) A commitment to act? Infographic. Available at: www.health.org.uk/infographic-commitment-act (accessed 4 August 2017)

Jones B, Woodhead T (2015) Building the foundations for improvement: how five UK trusts built quality improvement capability at scale within their organisations. Health Foundation, London. Available at: www.health.org.uk/publication/building-foundations-improvement (accessed 4 August 2017)

Mate K, Rakover J, Munch D, Pugh M (2017) Ensuring healthcare improvements stick. *Healthcare Executive* 32 (1): 66–69

Morton J (2014) The first metabolic and bariatric surgery accreditation and quality improvement program quality initiative: decreasing readmissions through opportunities provided. *Surgery for Obesity and Related Diseases* 10 (3): 377–378

Mulley A, Trimble C, Elwyn G (2012) Patients' preferences matter: stop the silent misdiagnosis. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/patients-preferences-matter (accessed 4 August 2017)

Orsini JD (ed) (2013) The essential Deming: leadership principles from the father of quality. McGraw-Hill Professional, New York

Øvretveit J (2009) Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers. The Health Foundation, London

President's Council of Advisors on Science and Technology (2014) Better health care and lower costs: accelerating improvement through systems engineering. Report to the President. Available at: www.himss.org/better-health-care-and-lower-costs-accelerating-improvement-through-systems-engineering (accessed 4 August 2017)

Scottish Government (2010) The healthcare quality strategy for NHS Scotland. The Scottish Government, Edinburgh. Available at: www.gov.scot/Publications/2010/05/10102307/0 (accessed 4 August 2017)

Senge P (1990). The fifth discipline: the art and science of the learning organization. New York: Currency Doubleday.

Swensen S, Pugh M, McMullan C, Kabcenell A (2013) A high-impact leadership: improve care, improve the health of populations, and reduce costs. Institute for Healthcare Improvement, Cambridge, Massachusetts. Available at: www.ihi.org/resources/pages/ihiwhitepapers/highimpactleadership.aspx (accessed 4 August 2017)

Wang MC, Hyun JK, Harrison M et al (2006) Redesigning health systems for quality: Lessons from emerging practices. *Joint Commission Journal on Quality and Patient Safety* 32 (11): 599–611

West MA, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1: 240–260

Further reading

Boaden R ,Furnival J (2016) Quality improvement in healthcare in Walshe K ,& Smith J (eds), *Healthcare Management*. 3 edn, UK Higher Education Humanities & Social Sciences Health & Social Welfare, Open University Press, England, pp. 454–478

Jones L, Pomeroy L, Robert G, Burnett S, Anderson J, Fulop N (2017How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England. *BMJ Quality and Safety* Published Online First: 08 July 2017. doi: 10.1136/bmjqs-2016-006433

Learning from others

Ham et al (2016) illustrate their core recommendation with case studies from abroad:

Building in-house capacity via a scientifically grounded method for quality improvement, investing in the education and training of all leaders and staff in this method.

Jönköping County Council in Sweden has done this by establishing a centre of expertise on quality improvement known as Qulturum on the site of one of its hospitals, and every year many staff participate in its training programmes.

In another example, Intermountain Healthcare in the US has pursued QI for more than 30 years. Thousands of its staff have graduated from its advanced training programme, which provides a grounding in QI theory and practice and requires participants to apply the learning in a project relating to their area of care. Participants come from wide ranging clinical and non-clinical roles with much of the training led by Intermountain's own staff.

A number NHS organisations committed to building in-house capacity (Jones and Woodhead 2015) include:

- East London NHS Foundation Trust
- Northumbria NHS Foundation Trust
- Nottingham Teaching Hospitals NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Sheffield Teaching Hospital NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust.

Patients and the public must be involved as equal partners in designing and implementing QI strategy. This requires clear understanding of patients' preferences and a commitment to build these into how care is improved (Mulley et al 2012).

Secondments

Secondments, offer staff the opportunity to work in a different organisational type or culture, to broaden their experience and skills and share their learning.

What is it?

Secondments are one way to increase levels of engagement and boost motivation in individuals with high potential. They provide novel development opportunities that expose employees to different environments and experiences to those of their own organisation. Secondments provide developmental opportunities that take employees outside of the boundaries of their roles, grades, teams or even organisations.

The aim is to give employees a chance to step outside their comfort zone, face new challenges, learn how to solve problems in the moment, learn lessons and apply them to their day-to-day work.

It is particularly useful for an employee to widen their perspectives by experiencing how a different organisation, with a different culture, systems and processes, may nevertheless achieve similar outcomes to their own.

Types of secondment may include (McKenzie 2003):

- strategic assignments
- secondments to help resolve conflict between employees
- financially incentivised assignments.

Why is it important?

Developing leadership talent is integral to building an engaged, healthy and motivated workforce with the capability and capacity to deliver high quality, compassionate care. Offering individuals with high potential opportunities that nurture and challenge them will enable them to grow and flourish into high performing leaders.

In a knowledge economy, secondments are an excellent way of sharing expertise, speeding up innovation and fostering understanding between different organisations and different professions.

For the individual, the benefits of an extra-organisational assignment include:

- getting to know a different context in which one's job or profession can be performed
- understanding the broader impact one's work can have
- understanding the interdependencies among different parts of organisations by experiencing different business models and operating models – especially important as we seek to integrate health and social care, develop systems working and promote place-based care
- learning different ways of getting things done, acquiring knowledge that will provide greater leadership capability
- the chance to innovate by transferring knowledge between the two organisations.

For organisations, the benefits include:

- opportunities to innovate by exchanging knowledge
- improving partnership with other organisations
- exploring opportunities for collaboration with other organisations at little cost and little risk (even if they fail)
- Enhancing their employees' overall profile, including among their professional networks.

What is the evidence?

Successful managers report that they learn from challenging assignments, other people, hardships and coursework. These are the major sources of executive learning, which have led to the 70:20:10 formula (McCall et al 1988). This involves structuring leadership development initiatives around:

- on-the-job experiential learning (70%)
- enrichment by vicarious learning from others such as mentors, coaches, bosses and colleagues (20%)
- formal learning (10%).

Successful managers report learning a wide variety of lessons from key developmental events, such as secondments. In the study Lessons of experience, McCall et al (1988) identified 32 different lessons from this type of developmental event, clustered into five categories:

- setting and implementing agendas
- handling relationships
- basic values
- executive temperament
- personal awareness.

There is also some evidence of gender and ethnicity differences in developmental assignments, including secondments. Women leaders obtain significantly fewer challenging assignments than male leaders.

In a US sample, African-American managers reported fewer challenging assignments, more hardship events and more role model events than white managers (Douglas 2003).

Critchley (2002) explored the use of secondments for the nursing profession in the UK and found these benefits:

- security – opportunity to have a novel experience within the security of their permanent role
- enablement – exposing high potential employees to new environments that allow them to develop new skills
- career advancement – new skills learned, giving employees additional competencies to add to their portfolio, increasing chance of promotion
- networking – cross-boundary working and broadening of connections from other staff groups/organisations
- diversity – working with different work colleagues, increasing openness to difference and more inclusive of diversity
- motivation – heightened levels of engagement and career ambition
- education – learning that can then be taken back to the primary organisation.

How is it done?

Developmental secondments provide the employee with extra-organisational learning experiences that can then be brought back to support innovation and quality improvement. In these assignments, three parties' needs and goals should be aligned:

- the employee's
- the host organisation's
- the parent organisation's.

Secondments can benefit all three by initially exposing the host organisation and the employee – and later, the original employer – to different work practices. But all parties must be clear about their responsibilities, expectations, accountabilities and performance objectives.

Typical secondments include:

- a healthcare employee seconded to a private sector company (such as an assignment that enables the employee to move up or down a step along the value chain)
- a professional firm seconding employees to work in-house with a client
- headquarters or corporate functions assigning staff to local, more patient-focused organisations
- job swaps between employees in equivalent organisations in healthcare or across health and social care.

These assignments place experience at the heart of development. They are most effective where knowledge-transfer is built in for both organisations. Experience-driven development asks three questions (McCauley and McCall 2014, McCall and McCauley 2014):

- What experiences have I had?
- What have I learned from those experiences, and how can I apply those lessons to other situations?
- What experiences do I need to broaden my perspective?

It is important to address the following specific questions before agreeing to a secondment (CIPD 2016):

- Is the secondment for a fixed term or for an indefinite period that is subject to notice?
- Although the original employer will generally be responsible for basic salary, what are the arrangements for other terms and conditions, such as overtime, expenses or training?
- What will happen in the case of long-term absence or persistent short-term absence?
- How will supervisory and disciplinary matters be dealt with?
- If the assignment is long-term, how will performance management and development be managed?
- Does indemnity insurance need to be provided?
- What happens if there are changes to the organisational structure (in either the host or the original employer) during the secondment?
- Who will fill the role in the seconding organisation, and how will the secondee retain contact with them?
- How will the end of the secondment be managed (for example, when the person returns to their original role)?

Tips

- Host organisations should not treat the assigned employee fully as theirs, nor should they see them as completely separate. Their role and mandate in the host organisation needs to be clearly communicated to all stakeholders in the host environment. Role boundaries and accountability must be clear and agreed in both organisations.
- Assignments should have an explicit developmental goal. Using these assignments as performance management tools, or placing poorer-performing individuals, will distract from the benefits of organisational learning and closer partnership between host and parent organisation.
- Employees must be ready for the assignment. Employees sent on secondment who lack political savviness or who are disorganised, overly dependent or not self-structured, will struggle.
- The transition back to the original employer must be well managed. On their return, employees must have the opportunity to review their experience and the learning that resulted from it, both for themselves and for their organisation. These insights should be integrated with their employer's QI processes.

References

CIPD (2016) Secondment: an introductory look into the different types of secondments and how to implement them most effectively. CIPD, London. Available at: www.cipd.co.uk/knowledge/fundamentals/people/development/secondment-factsheet (accessed 2 August 2017)

Critchley D (2002) Second sight: Deborah Critchley spells out ten reasons why not to miss the chance of a secondment. *Nursing Management* 9 (7): 12–13

Douglas CA (2003) Key events and lessons for managers in a diverse workforce: a report of research and findings. Center for Creative Leadership, Greensboro NC

McCall MW Jr, Lombardo MM, Morrison AM (1988) The lessons of experience: how successful executives develop on the job. New Lexington Press, San Francisco CA

McCall Jr MW, McCauley CD (2014) Experience-driven leadership development. In McCall Jr, Morgan W, McCauley CD (eds) Using experience to develop leadership talent. Pfeiffer, San Francisco, CA

McCauley CD, McCall Jr MW (2014) Using experience to develop leadership talent: how organizations leverage on-the-job development. John Wiley and Sons, Chichester

McKenzie J (2003) Secondment benefits. McKenzie and Associates. Published online at: www.secondments.com/secondment.html (accessed 20/07/17)

Further reading

Ellis DW (2011) A second look at secondments. *Benefits and Compensation International* 40 (8): 3–4, 6, 8

Espinoza J (2011) When a stint elsewhere reaps benefits. *The Wall Street Journal* (Europe), 1 March: 27

Fearn H (2013) How to get promoted after a civil service secondment. *Guardian Professional*. 5 September

Fox A (2011) Paths to the top: do assignments outside HR pay off? *HR Magazine* 56 (11): 30–35

McWhinney S, Jobling B (2014) Second changes. *Employers' Law*. October: 18–19

Developmental assignments

Most of us typically learn through situations that arise naturally during our working lives. But this may leave gaps. Developmental assignments provide a more strategic approach, tailored to a staff member's needs.

What is it?

Developmental assignments come in many shapes and forms, but essentially are tasks to help an individual develop their skills. Developmental assignments are arguably the most useful learning experiences that leaders can have, if they are thought through and well structured. They may include key job challenges, such as:

- unfamiliar responsibilities – handling responsibilities that are new or different from previous responsibilities
- new directions – starting something new or making strategic changes
- inherited problems – fixing problems created by someone else or existing before the assignment
- problems with employees – dealing with employees who lack adequate experience, are performing poorly or who are resistant to change
- high stakes – managing work with tight deadlines, pressure from above, high visibility and responsibility for critical decisions
- scope and scale – managing work that is broad in scope (involving multiple functions, groups, locations, products or services) or large in size (for example, workload, number of responsibilities)
- external pressure – managing the interface with important groups outside the organisation, such as the media, patients, carers, suppliers, partners, unions, and regulatory agencies
- influence without authority – influencing peers, senior management, system leaders or other key people over whom you have no authority
- work across cultures – working with people from different cultures or with institutions in other countries
- workgroup diversity – being responsible for the work of people from different professional backgrounds, varying demographic backgrounds (including gender mix, age differentials, different country of origin, different racial and ethnic backgrounds) and different skill levels and experience.

Developmental experiences vary from one organisation to another. The relative frequency of the key events that are reported is affected by the demands put on the organisation by its function (ambulance, mental health, primary care, community, acute), patients and technology (among others). Senior managers' attitudes and values also influence the pattern of developmental assignments – for example, how stretching and bold they are.

Developmental assignments can broaden a leader's skills or target a specific skill or competency.

Tip: For excellent suggestions for developmental assignments to target specific competencies, see McCauley (2006) or Lombardo and Eichinger (1989, 2003, 2009).

Why is it important?

Leaders need to continuously refine their skills and acquire new capabilities throughout their careers to remain effective. Most leaders begin their careers with clear strengths that they bring to their work. But to be effective in a wide variety of leadership roles and situations, they have to master new skills in new areas. A significant part of this development takes place through practical experience.

We learn when our day-to-day responsibilities and challenges require it, and when we engage in experiences, draw lessons and insights and apply the knowledge and skills to the next experience. So the more varied the practical experience is, the greater the likelihood of developing a broad repertoire of skills.

Leaders who step into new situations and face challenges that call for untested abilities continue to develop their capacity and to successfully take on higher levels of leadership responsibility. They apply their strengths to their 'stretch' experiences, but are aware these experiences enable them to discover deeper knowledge and hone new capabilities.

What is the evidence?

As well as learning from challenging assignments, other people, hardships and coursework, successful managers occasionally mention that a personal life event had an impact on the way they manage (McCall et al 1988). These are the major sources of executive learning, which have led to the 70:20:10 formula. (To see more on this, go to Secondments.)

Developmental assignments include first supervisory jobs, start-from-scratch assignments, fix-it assignments, negotiations, projects and task forces, moves between staff and line jobs, increases in scope and career shifts (McCall and Hollenbeck 2002, Ruderman and Ohlott 2000).

Effective leadership honed from developmental assignments needs to be tempered by core values, such as compassion and a realistic sense of self – including one's strengths and limitations (McCauley et al 2013).

Developmental assignments versus hardships

Although developmental assignments are demanding, they typically end in success. Hardships, on the other hand, are experiences of failure and loss. They include mistakes, demotions or missed promotions, subordinate performance problems, downsizing experiences, conflicts in the workplace, experiencing prejudice and discrimination and personal traumas.

Managers can learn from both experiences, enabling them to broaden their repertoire. Successful managers report learning a wide variety of lessons from key developmental events. In Lessons of experience, McCall et al (1988) identified 32 lessons in five categories:

- setting and implementing agendas
- handling relationships
- basic values
- executive temperament
- personal awareness.

The authors found patterns between the lessons learned and the events that produced them. For example, lessons about setting and implementing agendas were most likely to come from challenging assignments, while basic values were learned from other people, and personal awareness came from hardships.

There is also some evidence of gender and ethnicity differences in developmental assignments. Women leaders obtain significantly fewer challenging assignments than male leaders. In a US sample, African-American managers reported fewer challenging assignments, more hardship events and more role model events than white managers (Douglas 2003).

How is it done?

Reviewing global good practice in developmental assignments, McCauley et al (2013) come up with four broad recommendations:

- Make developmental assignments intentional – Many leaders experience developmental assignments as they randomly come up (for example, driven by crisis situations and changing business environments). Few go through a developmental assignment purposefully selected for them. Good practice involves purposefully matching people to assignments, as well as widening their availability to leaders across all levels and demographic backgrounds. This can be done as part of the annual talent review. [link]
- Make developmental assignments more valuable – This involves providing learning support for staff on a developmental assignment, such as coaching, mentoring or regular supervision. Action learning sets are another way to include peer support, to maximise learning from developmental assignments. Other approaches include formal learning reviews, learning logs or learning contracts.
- Structure talent development systems and processes to embrace developmental assignments as a valuable and frequent tool for leadership learning – Many organisations have formal systems and processes for selecting and developing leadership talent. But not all build in experience-driven development, or even embed them in the organisation's core values around development. Those that do this create more value for the organisation from developmental assignment and give more recognition to employees who successfully complete them.
- Ensure the organisation is an enabler of experience-driven learning, rather than an obstacle to it – Many aspects of an organisation (including its shared values, its employees' behaviours and perceptions, its processes and its routines) can either support or hamper experience-driven development. Organisations need to ensure their culture is conducive to learning from experience, including learning from failure and mistakes. A climate of trust and openness is conducive to this, as is the availability of ongoing feedback. Organisations need to provide ways to capture insights from experience-based development and connect this with relevant processes for innovation and quality improvement (DeRue and Wellman 2009).

References

DeRue DS, Wellman N (2009) Developing leaders via experience: the role of developmental challenge, learning orientation, and feedback availability. *Journal of Applied Psychology* 94: 859–875

Douglas CA (2003) Key events and lessons for managers in a diverse workforce: a report of research and findings. Center for Creative Leadership, Greensboro, NC

Lombardo MM, Eichinger RW (1989) Eighty-eight assignments for development in place. Center for Creative Leadership, Greensboro, NC

Lombardo MM, Eichinger RW (2003) For your improvement: a development and coaching guide (third edition). Lominger, Minneapolis

Lombardo MM, Eichinger RW (2009) FYI: for your improvement. A guide for development and coaching. Korn/Ferry International, place

McCall MW Jr, Hollenbeck GP (2002) Developing global executives: the lessons of international experience. Harvard Business School Press, Boston

McCall MW Jr, Lombardo MM, Morrison AM (1988) The lessons of experience: how successful executives develop on the job. New Lexington Press, San Francisco

McCauley C (2006) Developmental assignments: creating learning experiences without changing jobs. Center for Creative Leadership, Greensboro, NC

McCauley CD, DeRue DS, Yost PR, Taylor S (2013) Experience-driven leader development: models, tools, best practices, and advice for on-the-job development. John Wiley and Sons, Chichester

Ruderman MN, Ohlott PO (2000) Learning from life: turning life's lessons into leadership experiences. Center for Creative Leadership, Greensboro, NC

Further reading

Byham WC, Smith AB, Paese MJ (2002) Grow your own leaders: how to identify, develop, and retain leadership talent. Prentice Hall, New York

Dalton MA (1998) Becoming a more versatile learner. Center for Creative Leadership, Greensboro, NC

McCauley CD, Martineau J (1998) Reaching your development goals. Center for Creative Leadership, Greensboro, NC

McCauley CD, Ohlott PO, Ruderman MN (1999) Job challenge profile facilitator's guide: learning from work experience. Jossey-Bass, San Francisco CA

Ohlott PO (2004) Job assignments. In McCauley CD, Van Velsor E (eds) The Center for Creative Leadership handbook of leadership development. Second edition. Jossey-Bass, San Francisco CA: 151–182)

Case studies

There are many case studies for developmental assignments in practice. Ample evidence for structuring such experiences is available from the public and private sectors. McCauley et al (2013) provide a collection of cases and summaries for good practice.

Action learning

Action learning is a group approach to learning through a project, in which participants work together to identify and examine solutions to a real organisational challenge.

What is it?

Action learning is a project-based approach designed to develop discrete and manageable improvement opportunities for leaders and all staff.

The approach involves bringing together a group of leaders (or other staff) to address a known organisational issue or challenge. This provides a guided, integrative, real-time process that addresses complex challenges while developing individual, team and organisational capacity for leadership. It is a versatile organisational capability that, once developed, can be applied to a wide range of issues in the organisation or across a system.

The projects may range in size and scope:

- Small projects – Action learning projects may be short-term, limited in scope and aimed at those being developed, with some involvement from senior leaders. They are not necessarily expected to fundamentally transform how the organisation operates.
- Larger projects – They can be aimed at key strategic challenges and opportunities. In this case, they tend to be broad in scope and ongoing – for example, managing the organisation's relationships with the local media or working across the sustainability and transformation partnership. They are aimed at transformation and learning for senior leaders, including the executive team. They are expected to fundamentally transform how the organisation operates.

Action learning builds leadership capabilities while addressing real business needs. Participants work in learning groups to identify and examine solutions to the organisation's critical leadership challenges. At the same time, they learn about leadership and development at the individual, team and organisational levels.

The organisation benefits from the resulting financial savings and new strategic plans developed during the action learning projects and the changes the participants make within their direct line of responsibility.

Action learning is different from traditional training, which involves:

- individual learning
- a focus on skill and knowledge acquisition
- teaching by experts using case studies and hypothetical situations.

In contrast, action learning involves:

- learning with coaches and other action learning team members
- a focus on behavioural and system change
- a focus on current organisational challenges
- learning at individual, team and organisational levels simultaneously.

The origins of action learning

Working with a number of leading global organisations, the Center for Creative Leadership (CCL) influenced the development of this approach to building leadership capacity while successfully leading change and transformation across an organisation (McCauley and Brutus 1998).

Why is it important?

Action learning combines leadership development and organisation development in one seamless activity that strengthens leadership and improves organisational performance at the same time.

Because participants work in groups with others from across (or even outside) the organisation, the approach builds relationships vertically, horizontally and across boundaries to enhance the organisation's capacity to implement its strategies and adapt to change. It involves a vertical and horizontal cross-section of leaders, working on real issues and opportunities together.

The approach is strengthened by close attention to assessment, learning and capability development in addition to problem solving. It connects members of the senior team to other leaders across the organisation, providing senior leaders with first-hand exposure to others. Finally, it focuses on building individual leaders' capabilities as well as strengthening the organisation's collective leadership.

What is the evidence?

Successful managers report that they learn from challenging assignments, other people, hardships and coursework. These are the major sources of executive learning, which have led to the 70:20:10 formula. (To see more on this, go to Secondments.)

Action learning projects are an ideal way to contribute to managers' experiential learning in a carefully structured way.

Organisations have reported the value of action learning programmes in solving problems, developing leaders, building teams and transforming their cultures over many years. However, little rigorous research has evaluated action learning. Leonard and Marquardt (2010) reviewed 21 refereed articles, theses and dissertations that measured its impact. Their review concluded that:

- action learning develops broad executive and managerial leadership skills, particularly collaborative leadership and coaching skills
- action learning improves managers' ability to develop integrative, win/win solutions in conflict situations
- factors consistently identified as critical to the success of action learning include participants questioning, taking action, learning from group members, listening, valuing group diversity, developing confidence and a sense of wellbeing, a psychologically safe environment and the presence of a coach
- successful action learning requires skilled team-level coaching, diversity, self-directed team processes, effective team presentations, review of team and organisation-level processes for ensuring solutions are implemented, alignment and importance of the problem, top decision-makers' support and the availability of organisational resources.

How is it done?

Action learning challenges leaders to think and act differently. It provides opportunities to focus on a more systemic array of change issues, such as systems working, and prompts reflection on prevailing practices and beliefs that influence the organisation's approach to complex challenges.

Action learning: steps in the process

1. Secure senior managers' support.
2. Establish strategic mandate (tied to business strategy).
3. Determine primary focus (organisational or individual).
4. Decide whether the action learning will be via team projects or individuals working on problems. (The former is preferable for development.)
5. Determine the role of learning coaches (senior leaders in the organisation) and how they will be found.
6. Select the participants.
7. Recruit sponsors (senior leaders) and clarify their role.
8. Clarify whether a coach is needed to facilitate the process and learning, and identify an appropriate coach.
9. Choose projects.
10. Identify and brief project stakeholders.
11. Determine length of time required.
12. Determine learning outcomes.
13. Deliver an introductory workshop.
14. Ensure the approach is aligned with HR systems.
15. Co-design an evaluation.

The key elements of the process are:

Planning elements

- Prework – This involves selecting the participants (project teams or individuals). It probably includes reading reports, media stories, analysts' reports or strategic documents and conducting focus groups, interviews and assessments.
- Engaging support – The action development process then engages the senior team to support the work.
- Planning the key strategic initiatives – This includes defining the initiatives and processes for participant development.

Main project elements

- Getting started – The participants plan, assess and execute the initiatives as part of their development.
- Data collection and analysis – They begin to interpret the data and draft preliminary recommendations.
- Finalising recommendations – Participants collectively establish their final recommendations, prepare the presentations and gain support from a key executive-level sponsor.
- Presenting recommendations – The participants present their strategic recommendations to sponsors, establish agreements on next steps and share best practices with all participants.
- Review – The participants take part in an after-action review, including reflection on critical learnings.

Tips

- Prepare participants before starting. Address any concerns about how much time the projects require on top of existing workloads by changing the project scope, making the projects the focus of their work and/or delegating some of their existing work to others.
- Make sure the focus is on learning first and action/outcomes second.
- Align projects with organisational strategy and vision.
- Provide projects that are broad and complex to work on.
- Encourage participants to experiment and implement change, knowing they will have strong support.
- Do not require pre-specified results
- Ensure implementation and hand-offs of projects are planned and supported.

Case studies

In one example (Catholic Healthcare Partners), participants created and strengthened cross-regional and cross-functional networks. This resulted in a deeper understanding of the organisation as an interrelated system and provided a venue for sharing ideas and best practices. The action learning projects resulted in important organisational-level outcomes. These included a more comprehensive focus on diversity in the workplace and clarity in partnerships with other healthcare facilities.

Overall, the 26 participants advanced 15 key initiatives through the action learning projects. Key success factors included:

- the senior team's involvement and support
- finding the right projects
- finding the right participants; this included ensuring a high level of diversity, representatives from minority groups and a high level of cross-functional representation.

www.ccl.org/wp-content/uploads/2015/03/chp.pdf

References

Leonard HS, Marqardt MJ (2010) The evidence for the effectiveness of action learning. *Action Learning: Research and Practice* 7 (2): 121–136

McCauley CD, Brutus S (1998) Management development through job experiences: an annotated bibliography. Center for Creative Leadership, Greensboro, CA

Rabin R (2014) Blended learning for leadership: the CCL approach. Greensboro, NC. Available at: www.ccl.org/wp-content/uploads/2015/04/BlendedLearningLeadership.pdf accessed 20 July 2017

Action learning sets

This approach involves learning in teams and applying new skills to real-life working situations to develop an integrated, experiential form of learning.

What is it?

Action learning sets are small groups of people who work together in a supportive and confidential learning environment. Participants identify a situation they want to change, then work alongside their colleagues to dedicate time and effort to tackle the challenge in a safe environment (Cumming and Hall 2001).

The fundamental aims of action learning sets are to help participants develop the skills and make time for reflection to solve their problems. See also Action learning.

They create safe spaces that are ripe for problems to be shared, discussed, advised on and taken back to the workplace for testing and evaluation.

A slight variation is the action learning leadership set. This is for developing leadership capabilities while, again, addressing real challenges within a team or organisation. Participants work together in groups to explore challenges, generate ideas for solutions, weigh options and test possible solutions. The emphasis is on learning about leadership and development at the individual, team and organisational levels.

By sharing an issue with colleagues and fellow leaders in the learning set, the leader can learn from others' ideas and experiences, gaining different and deeper insights as well as self-awareness.

Why is it important?

Action learning sets give individuals the opportunity to learn through experience and reflection, in a team setting. They have been used across sectors and industries, both in leadership development programmes and in real work contexts. There are widespread reports of their value as an experiential learning process.

Action learning sets are especially important in the NHS, as they offer staff the space to reflect and learn from one another. This is particularly helpful for leaders who are likely to face unique yet comparable challenges. Action learning sets can be very effective, bringing leaders together to solve problems and learn.

Action learning sets provide these benefits (Revans 1998):

- cross-boundary learning
- increased flexibility
- a climate of active listening, openness and learning orientation
- improved communication
- collaborative working
- increased opportunity for innovation.

Because action learning sets often take place within the organisation, around real workplace issues, they are grounded in context. This makes them more likely to lead to tangible actions that result in real change and positive impact, for individuals and teams alike.

What is the evidence?

De Haan and De Ridder (2006) highlight these key advantages of action learning sets for individuals and organisations:

- opportunity to reflect
- mindful thinking and suspension of evaluative judgment or secondary processing, allowing questions to arise and be met with openness
- the chance to practise giving and receiving feedback
- psychological safety.

For organisations:

- developing practical skills
- teambuilding
- greater awareness of self and others in the team
- increased innovation
- development of skills for managing change
- opportunity for cross-boundary working
- improved wellbeing.

Results are similarly positive in healthcare. Young et al (2010) evaluated the use of an action learning set intervention for eight nurse consultant posts across two NHS trusts. Key outcomes included:

- benefits to patient care
- improved cross-organisational working
- development of change implementation skills at strategic levels.

Other studies (Hewison et al 2011, Watson et al 2006, Kim 1999) evaluated the use of action learning sets in nursing and found similar benefits. These conclusions are supported by many other case studies of action learning sets in practice (see Booth et al 2003, Giles 2000, Mumford 1996, Pedler 2011).

The NHS continues to move towards a more integrated system approach (for example, through STPs), cross-boundary working and collaboration action learning sets are an important and appropriate intervention.

How is it done?

The key elements of action learning sets are (Revans 1998):

- A problem – (project, challenge, opportunity, issue or task). Solving the problem should make a significant difference to the individual or organisation.
- An action learning group or team – Ideally, the team should comprise four to eight people who examine an organisational problem that has no easily identifiable solution. Diverse membership is valuable in contributing to the success of action learning.
- Ability to take action on the problem – The group must be able to act on the problem it is working on. Organisers must identify project sponsors to demonstrate the organisation's support for the action learning team.
- A commitment to learning – Action learning places equal emphasis on the learning and development of individuals and the team, as it does on solving the problems in question.
- Reflective questioning and listening – Action learning emphasises questions and reflection over statements and opinions. Open-ended questions (such as who, what, when, where, why and how) are the most powerful way to clarify the problem and consider strategies and solutions. The process of reflective questioning and listening builds group cohesion, promotes systems thinking, introduces innovative strategies and generates individual and team learning (see also Schön 1991).
- An action learning coach – The action learning coach helps team members reflect on what they are learning during the process and how

they are solving problems. Important steps require group members to reflect on how they listen, reframe the problem, give each other feedback, discuss how they plan and work together, and consider what assumptions may be shaping their beliefs and actions.

Research by Argyris (1993) highlights five key conditions for learning, which can be applied to action learning sets:

- context – learning should be focused around real issues that demand tangible action
- relevance – actions should be within a learner's capacity (knowledge, skills, experience) so they feel equipped and able to take action
- challenging – the problem to be solved needs to be a challenge, so that it sparks the need for non-routine and innovative thinking to solve it
- actionable – the ability to act in a timely way is important, and will ensure that the learning translates into impact
- pragmatic – it should be possible to generalise the learning so it helps future problem solving when similar issues come up.

Action learning sets can be understood better in the context of two important – but highly practical – theoretical concepts: experiential learning theory (Kolb 1984) and double-loop learning (Argyris 2002). We explain these below.

Experiential learning theory (ELT)

This theory defines learning as the major process of human adaptation (Kolb and Kolb 2005, 2009). The theory rests on a few key principles:

- Learning is best conceived as a process, not in terms of outcomes.
- All learning is re-learning.
- Learning is driven by conflict, dispute and disagreements.
- Learning is a holistic adaptation process.
- Learning takes place in context.
- Learning is the process of creating knowledge.

Action learning sets are designed to uphold these principles. Garratt (1991) recommends that the design of action learning sets emphasises the importance of an action learning cycle (versus an overly strong focus on action). This action learning cycle (informed by Kolb and Kolb's Experiential Learning Theory 2009) follows the following stages:

- analysis – a problem or issue is shared by a team member and analysed
- prognosis – a collective discussion takes place, using coaching-style questions, which explore problems rather than questions with implied solutions
- implementation – the team member takes away actions to implement in their work
- testing – the team member tests and evaluates the effectiveness of their actions and returns to the action learning set to feed back.

Double-loop learning

In double-loop learning the participant questions the method of pursuing a goal, but explores the value of the goal being pursued. In this way, mental models are challenged and new approaches created that are more relevant, context-specific and actionable.

Single-loop learning

Single-loop learning involves simply exploring the methods of achieving goals and includes taking action in pursuit of goals, noting which actions bring about errors, then reviewing and changing the process.

Single-loop learning has its place (Argyris and Schon 1989). However, double-loop learning goes much deeper. It questions the purpose of the actions in the first place, then works from the ground up to formulate a solution to the problem being discussed.

Action learning sets should be encouraged to use double-loop learning approaches (Revans 1998) by challenging assumptions about objectives, methods and processes in their work and through using coaching questions that go deeper than surface level inquiry. This will maximise the potential benefit of their discussions.

Tips

- Focus on problems that are 'wicked' – tough and apparently intractable – as well as more common difficulties.
- Make sure the group is made up of people from different disciplinary backgrounds, to increase opportunities for learning and innovation.
- Allow adequate time for discussion and action.
- Publicly celebrate the learning, progress and successes of action learning groups, to help embed them as good practice.
- Encourage participants to use their new skills of reflective questioning and listening in meetings and activities throughout the working day.

References

Argyris C, Schön DA (1989) Participatory action research and action science compared: a commentary. *American Behavioral Scientist* 32 (5): 612–623

Argyris C (2002) Double-loop learning, teaching, and research. *Academy of Management Learning and Education* 1 (2): 206–218

Argyris C (1993) Education for leading – learning. *Organizational Dynamics* 21 (3): 5–17

Booth A, Sutton A, Falzon L (2003) Working together: supporting projects through action learning. *Health Information and Libraries Journal* 20 (4): 225–231

Cumming Jo, Hall Ian (2001) Achieving results through action learning: a practitioner's toolkit for developing people. Peter Honey Publications, Maidenhead

De Haan E, De Ridder I (2006) Action learning in practice: how do participants learn? *Consulting Psychology Journal: Practice and Research* 58 (4): 216

Garratt B (1991) The power of action learning in Pedler M (ed) Action Learning in Practice. Gower publishing, Farnham

Giles G (2000) Report on accreditation learning sets in the West Midlands Region of the NHS. *Health Libraries Review* 17: 181–8

Hewison A, Badger F, Swani T (2011) Leading end-of-life care: an action learning set approach in nursing homes. I*nternational Journal of Palliative Nursing* 17 (3): 135–141

Kim HS (1999) Critical reflective inquiry for knowledge development in nursing practice. *Journal of Advanced Nursing* 29 (5): 1205–1212

Kolb AY, Kolb DA (2005) Learning styles and learning spaces: enhancing experiential learning in higher education. Academy of Management Learning and Education 4 (2): 193–212

Kolb AY, Kolb DA (2009) The learning way: meta-cognitive aspects of experiential learning. *Simulation and Gaming* 40 (3): 297–327

Mumford A (1996) Effective learners in action learning sets. *Employee Counselling Today* 8 (6): 5–12

Pedler M (2011) Action learning in practice. Gower Publishing, Farnham

Revans RW (1998) Sketches in action learning. *Performance Improvement Quarterly* 11 (1): 23–27

Schön D (1991) The reflective practitioner: how professionals think in action. Ashgate Publishing Ltd, Avebury

Watson J, Hockley J, Dewar B (2006) Barriers to implementing an integrated care pathway for the last days of life in nursing homes. *International Journal of Palliative Nursing* 12 (5): 234–241

Young S, Nixon E, Hinge D, McFadyen J, Wright V, Lambert P, Pilkington C, Newsome C (2010) Action learning: a tool for the development of strategic skills for nurse Consultants? *Journal of Nursing Management* 18: 105–110

Additional useful resources

Further resources which will help your work in this area

NHS Improvement hosts an Improvement hub which encourages users to share improvement stories and resources.
https://improvement.nhs.uk/improvement-hub/

NHSI's Advancing Change team runs several programmes:

Quality, service improvement and redesign (QSIR)
https://improvement.nhs.uk/resources/qsir-programme/

and: Transformational Change through System Leadership (TCSL)
https://improvement.nhs.uk/resources/tcsl-programme/

The Health Foundation web pages also offer a range of resources on innovation, skills and knowledge and evidence on what works and why.
www.health.org.uk/

The Horizons team host The Edge web page seeking to share, curate and create the boldest and most innovative new ideas in health & care.
theedge.nhsiq.nhs.uk/about/

Healthcare Improvement Scotland have an Improvement Hub, which supports health and social care organisations to redesign and continuously improve services
http://ihub.scot/quality-area

The US based Institute for Health Improvements web page contains a range of resources including tools on Improvement capability and patient safety
www.ihi.org/Topics/ImprovementCapability/Pages/default.aspx

Case Study 12

Who

Ashford and St. Peter's Hospitals NHS Foundation Trust

Programme name

Creating and sustaining the will for quality improvement and improving patient safety and staff engagement

What was the aim?

Quality improvement (QI) used to be associated with senior clinicians and managers. Today, most agree that healthcare leadership has to evolve from a top-down model to one of distributed or shared leadership to improve the care and experience of patients throughout the NHS.

Ashford and St Peter's Hospitals NHS Foundation Trust aimed to empower all staff to identify QI opportunities in their own areas and make improvements themselves.

What did they do?

We began our #Rightculture programme in 2014. Reflecting on lessons from the Francis report and the Savile Inquiry, we wanted to create a culture of 'curiosity and creativity' that was fair, open and supportive. We wanted staff to question the norm, to develop the capability and capacity to make improvements as teams and as individuals and not be bound by traditional hierarchies. We wanted to shift our culture and improve the feel of the trust, which had been typified by poor engagement scores in staff pulse surveys.

Shaping culture: Part I – building will

'Be the change', launched in February 2014, underpinned the #Rightculture programme. Conceived by junior doctors and based on social movement theory, it was inspired by the national NHS Change Day.

'Be the change' invites staff to offer ideas for improvement and creates opportunities for them to become 'change champions', developing new skills in their roles. The 2014 cohort was inspired to engage all staff in a campaign to be the change and identify the small improvements they wanted to make.

In the first year, staff submitted hundreds of postcards with ideas for improvement. More than 40 QI projects were launched with a junior doctor and local 'change champion' leading each one. The executive team supported full implementation of the top three ideas.

Shaping culture: Part 2 – building capability

We then developed an approach to increasing QI capability. This includes harnessing our internal knowledge and skills to build a broad understanding of improvement methodology that is simple and repeatable. It also ensures data, measurement, problem-solving and plan-do-study-act skills are taught at all levels of the organisation.

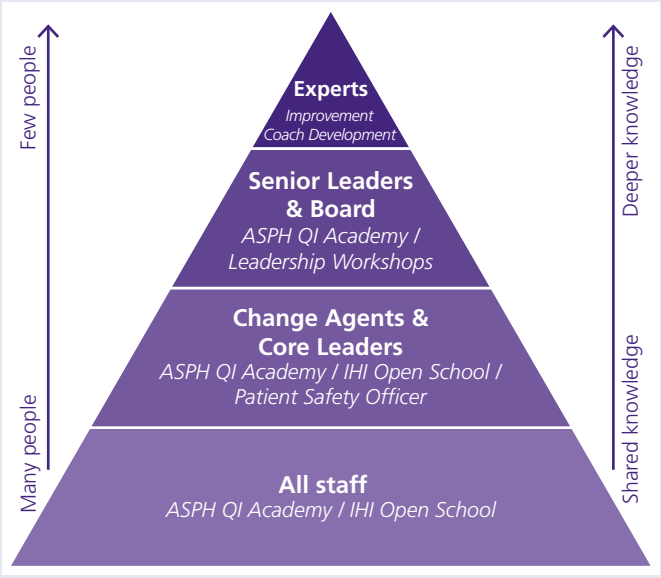


Figure 1: Building Capability

By finding ways to share learning, we highlighted successful teams operating without hierarchy. Through the programme we invested time in helping teams create the conditions for QI to flourish, and carried out team and individual coaching.

Shaping culture: Part 3 – do your work and improve your work

The 'Be the change' programme has spread and is now a vital part of the trust's QI strategy. To do this we moved from postcards to online portals for submitting ideas for change. In the last two years we expanded QI teaching to the whole organisation, created an online portal for any staff member to submit an idea and launched a 'Be the change' mobile app – making this initiative accessible, modern and developmental.
www.bethechangeasph.com

What are the outcomes?

Figure 2 shows the scale and diversity of the trust's QI work over 12 months.

Supporting QI empowered our teams to be creative, innovative and constantly looking for ways to improve our services and our care. We created leaders who created and supported the capability for learning – and therefore change – at scale. This enabled us to improve the patient experience, our patient safety metrics and the feel of the organisation.

A significant factor in the #Rightculture programme was a concern that, despite our relative success as a foundation trust, we had failed to improve our staff survey results, which at best were average. In 2016, results for 77 out of 88 questions had improved on the previous year. In the past five years, we have seen double-digit percentage increases in all four questions relating to innovation and improvement

In 2017, we won the Healthcare People Management Association (HPMA) Excellence Awards – for excellence in employee engagement.

What were the learning points?

Bottom-up change brings significant benefits to any organisation striving to deliver high quality care while demand increases and funding is restricted.

Supporting all staff to do QI:

- teaches improvement skills
- encourages innovation and experimentation
- increases ownership of improvement
- improves the patient experience
- encourages a sense of belonging in the organisation
- makes continuous improvement part of the culture.

In addition, we are aligning this work to our quality priorities by:

- developing leadership skills and behaviours for QI and creating the conditions to allow QI to flourish
- developing QI objectives for all core leaders.

Our Chief Executive, Suzanne Rankin, recently wrote that: "We are embracing QI, not only because it is the right thing to do, but because it will help us achieve the culture of curiosity and creativity where we all feel empowered and confident in looking for improvements for the benefit of our patients."

We have learned that aligning our transformation programmes and QI activities with our patient safety, organisational development and leadership strategies is essential to our aim of supporting a culture of 'curiosity and creativity'.

For further information please contact:
Louise McKenzie, Director of Workforce Transformation, Ashford and St Peter's Hospitals NHS Foundation Trust – Louise.Mckenzie@asph.nhs.uk

While this organisation did not use NHS Improvement's culture toolkit, it created its own culture journey to make improvements, acknowledging the importance to the NHS of developing compassionate and inclusive cultures.

Case Study 13

Who
Leeds Teaching Hospitals NHS Trust

Programme name
Measuring progress and celebrating success with safety huddles

What was the aim?

Leeds Teaching Hospitals NHS Trust (LTHT) wanted to take a whole-team approach to reducing patient harm.

What did they do?

Ward teams now meet every day in a 'safety huddle' to discuss patient harm such as falls, pressure ulcers and avoidable deterioration.

"The ward team meets for a five to 10-minute focus around a safety issue relevant to their patients," says Alison Cracknell, Consultant Geriatrician. "For example, on an older people's ward the team will look at 'who are we most worried about falling today, and what actions can we take as a team to prevent harm?' They review data – for example, days since the last fall – celebrate milestones and share learning about why the last patient fell."

Staff from all roles and seniority levels update the team with information and insights into individual patients' risk levels and the action they plan to prevent harm. Healthcare assistants, housekeepers, students and therapists are often central to information gathering, and feel able to voice their concerns and insights to medical and nursing colleagues.

Visual displays and reminders show the importance that teams place on safety. Eye-catching signs displaying the number of days since the last harm event are updated in the huddle.

Milestones in performance are marked by presenting certificates to teams

"A week between falls was a rare event on a medical ward," says Dr Cracknell. "So the idea began of celebrating 10 days as a bronze certificate, silver for 20 days and what seemed unachievable – gold for 30 days between falls."

Medical admissions reached this seemingly impossible target of 30 days without a fall, while one older people's ward went 56 days. The neuro-rehabilitation unit achieved more than 100 days between falls, and a cardiology ward went over 130 days between cardiac arrests.

After hearing a presentation by Dr Anna Winfield – Patient Safety and Quality Manager, on involving non-clinical staff in promoting patient safety, Paul Tobin, a porter at St James's Hospital, and colleagues introduced portering patient safety huddles – the first of their kind in the UK. These build on the portering team's unique access to every ward and clinical area, and take place twice a week.

Porters across the trust highlight issues and discuss improvements to patient safety. Their regular contact with staff and patients means they are ideally placed to propose changes that make a lasting difference to patients' comfort and safety.

Guest speakers are regularly invited to attend the huddle to raise awareness of specific patient safety issues. The infection control team, information governance team, cystic fibrosis specialist nurse, blood products team and haematology matron have all shared valuable insights.

Issues raised by porters have led to action to improve patient safety and experience: for example, their work with the blood bank helped reinforce the correct procedure for ordering blood products.

Dr Winfield says: "Porters are an essential part of our multidisciplinary team, and through their huddles have raised awareness of their valuable role and made many positive contributions to patient safety. They recently won an LTHT 'Time to shine' award for best support team. It is a privilege to work with such a fantastic team."


News

Porters score UK first with new safety huddles

An exciting new initiative launched by members of the portering team at Leeds Teaching Hospitals is making a real impact on patient safety and has

What were the outcomes?

All team members see the huddles as a daily investment to improve patient outcomes and staff morale.

The huddles include regularly measuring progress and celebrating success, helping teams to continually learn and improve. Teamwork and safety culture measurements have shown positive changes. Ward staff report that the huddles encourage healthy competition: if the ward next door can get to 20 days between falls, another wants to get to 30. Staff say they feel more confident in the huddle to speak up about patient safety concerns. In addition, non-clinical staff such as housekeepers reported increased job satisfaction and a sense of feeling part of the wider multidisciplinary team.

After two-and-a-half years, more than 90% of wards have a daily huddle. Across the trust, falls and cardiac arrests have reduced by 25%, safety culture has improved and staff feel recognised for their work.

What is the learning ?

Our approach uses the science of improvement methodology and the art of coaching. It takes time and patience. The huddle brings people together to give them a voice and role in safety. It brings non-stop learning, testing new ideas, developing, sharing, listening, talking, collaborating and celebrating. It requires people with improvement and engagement skills to coach – and learn with – each team as they test and adapt huddles. No two wards are the same.

The key to success is empowering teams that work together to improve together by using QI methods at scale and creating a learning environment. The executive team's support for ward teams, and its pride in their achievements, enabled the work to flourish in a way that engages and energises local teams. Discussing ward-level data in the huddle brings ownership and a belief that new milestones can be achieved. Celebrating teams' results drives them to go even further.

For further information please contact: anna.winfield@nhs.net and a.cracknell@nhs.net

This work was supported by the Yorkshire and Humber Improvement Academy and The Health Foundation.

While this organisation did not use NHS Improvement's culture toolkit, it created its own culture journey to make improvements, acknowledging the importance to the NHS of developing compassionate and inclusive cultures.

Case Study 14

Who
South West Patient Safety Collaborative/South West Academic Health Science Network

Programme name
Safer Culture, Better Care

What was the aim?

To provide safer care for patients by assessing and improving safety culture in healthcare teams in the South West (Devon, Somerset and Cornwall).

What did they do?

We gave teams from acute and mental health trusts, GP practices and care homes the opportunity to assess their safety culture using the SCORE survey, a safety culture assessment tool with seven domains:

- teamworking
- local leadership
- learning environment
- burnout
- personal burnout
- safety
- work-life balance.

The patient safety collaborative helped in introducing the survey, achieving a significant response and debriefing the teams on the results. It then helped identify areas for improvement for the teams to follow up, but teams decide their own priorities for improvement. Teams repeat the survey after a time to see if any changes they made have affected the results. So far, 44 teams in the South West have taken part in the first round of surveys and are now working on identified improvements.

What are the outcomes?

Four teams from acute hospitals, mental health and primary care have done a second survey, and results have improved in all but one team.

Examples of interventions and improvements:

Team 1: (acute trust)
After the first debriefing, the team:

- helped appoint a new clinical educator for nurses
- increased opportunities for simulation training
- gave greater recognition to administrative staff's crucial role in the team, leading to an increase in their number
- focused on giving positive feedback.

The second set of results showed staff perception across all the SCORE survey domains was more positive by several percentage points.

Team 2: (GP practice)
After the debriefing, the team introduced a 'learning from excellence' pilot, and increased education and communication at six weekly meetings.

The second set of results showed more positive responses across the domains – for example, the

local leadership domain (focusing on the amount and quality of feedback individuals receive) increased by 12 percentage points.

Team 3: (mental health trust)

This team's initial results prompted it to improve teamwork by empowering staff to make changes, celebrating good work at regular best practice meetings, eliminating unnecessary email traffic and increasing personal communication.

In the second survey, the perception that the team worked together in a well co-ordinated way increased, while perceptions of team burnout and feelings of personal burnout decreased. Overall the increase in positive results was marked.

Team 4: (acute trust)

This team introduced a quality improvement session to its safety days, provided training on giving feedback and other communication skills, and made changes where frustrations were felt (eg time allowed to write workout rotas to ensure they were published six weeks in advance). It also had a small uplift in staff numbers following the first survey.

The second survey's overall results were slightly less positive than the first. This helped the team understand how the increased workload and resulting pressures had affected it.

There were some pockets of improvement – for example, one group felt more positive about local leadership and feedback received by between 14% and 28%. This group's feelings of personal burnout also decreased by 51%.

What is the learning?

Setting up a debriefing process that focuses on safety culture was key to identifying improvements: it can assist in opening lines of communication to improve safety, celebrate success and empower teams to make changes.

The results encouraged teams to reflect on how they work as a team and hold non-judgemental discussions. Focusing on patient safety during debriefing celebrates the good while identifying potential improvements. Focusing on positive behaviours helps create a safe environment to discuss how the team functions rather than concentrating on individuals.

- identify a 'local champion' to explain to staff how the results will be used and promote survey completion. This local champion will lead the improvement work
- define who is in the team and where the boundaries are
- culture is team-specific, and ways of improving culture are equally specific
- psychological safety is crucial for a positive safety culture – emphasise early on that the survey is anonymous and responses cannot be traced to individuals
- focus on team behaviours
- trust the team.

For further Information please contact: Joanna.pendray@swahsn.com and matt.hill1@nhs.net

While this organisation did not use NHS Improvement's culture toolkit, it created its own culture journey to make improvements, acknowledging the importance to the NHS of developing compassionate and inclusive cultures.

Case Study 15

Who
Sheffield Teaching Hospitals NHS Foundation Trust

Programme name
Reducing mortality and length of stay through a frontline-led programme

What was the aim?

The Sheffield Microsystem Coaching Academy (MCA) is led by the trust in partnership with the Dartmouth Institute Microsystem Academy in the United States and healthcare organisations across Sheffield. After MCA supported a successful improvement programme with Sheffield's cystic fibrosis department, the trust's lead consultant for respiratory medicine asked for their help to improve the quality of care in four acute inpatient wards at the Northern General Hospital.

What did they do?

The team began by holding meetings for all ward staff to ask what they thought they did well and what could be improved. Processes that could be improved included:

- variability in how the wards were organised
- the way information was shared between professionals
- accessing test results
- medicines management.

MCA coaches helped ward staff collect data to understand the ward systems, how staff worked and how long tasks took. The data included outcomes, length of stay, patient types, demographics and incidents, as well as feedback from staff and patient stories.

Next, ward teams set up a 'change' room displaying all the data, and invited colleagues to comment on it. They scheduled weekly meetings on Fridays, with an open invitation to all ward staff. Over several meetings, the coaches helped staff to generate priority themes for improvement and map key processes. These generated many ideas for improvement, including:

- **board rounds** – all multidisciplinary team members meet in front of the whiteboard at the nurses' station and discuss each patient in turn; the team designed a standard checklist briefly covering the patient's diagnosis, to review whether the patient is fit for discharge or sick and needing immediate review; the board round also highlights any social issues to address
- **huddles** – meetings lasting five to 10 minutes between team members to exchange information about a patient's current situation
- **pharmacy runs** – a system to ensure medicines orders are quickly taken to pharmacy, and completed TTOs (to-take-out medicines) are quickly brought back to the ward

- **near-patient testing** of INR (international normalisation ratios) for people on anticoagulation therapy – 'near' refers to testing outside a clinical laboratory
- **ward round checklists** to ensure consistent documentation for each patient.

What are the outcomes?

The programme resulted in a wide range of improvements, including:

- establishing new communication processes like board rounds and huddles, which have been built into the daily ward routine and sustained
- doubling the number of patients using the discharge lounge, freeing bed capacity earlier and improving flow
- reducing the time nurses take to do daily medication rounds, on average by 15 minutes
- introducing open visiting rather than restricting it to certain times (a change embraced by the wider hospital)
- redesigning stock storage to make stock easier to find, manage and replenish, reducing wastage
- a new system of patient flow management with ward staff identifying appropriate patients in the hospital and 'pulling' them through to the right bed on the right ward, reducing delays and errors.

These have combined to produce wider system-level improvements: notably, a sustained reduction in length of stay (see Figure 1) and reduced hospital standardised mortality ratio (HSMR) – (see Figure 2).

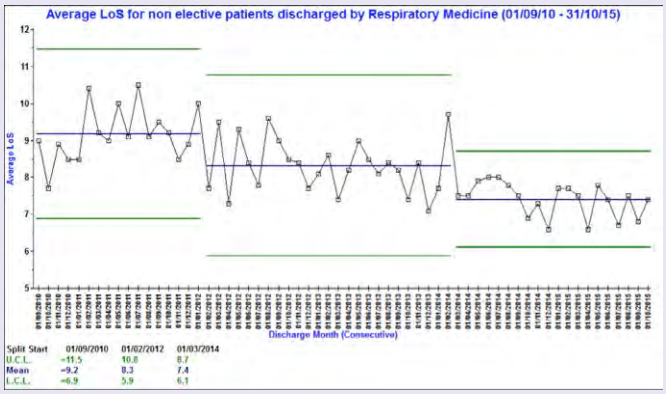


Figure 1: Changes in length of stay

(Source: Sheffield Teaching Hospital NHS Foundation Trust information services data)

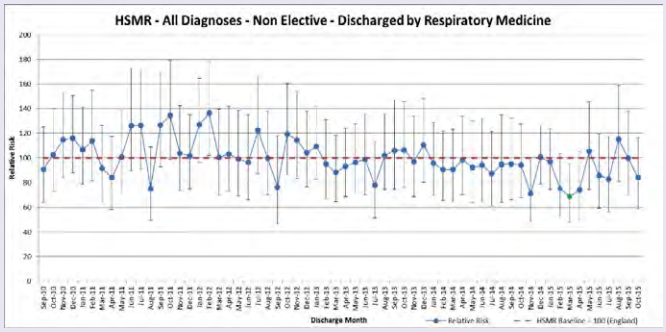


Figure 2: Changes in mortality

(Source: Dr Foster)

The 'change' room continues to meet fortnightly five years after the work began, with new tests of change introduced on an ongoing basis. The ethos has been that this is not an improvement 'project' but a new way of working where improvement becomes embedded and sustainable. There have been high levels of engagement from staff to make the system work better for patients and to improve the working day.

What is the learning?

- involving all staff can lead to major quality improvements
- frontline staff can initiate changes and test processes with high impact
- multiple small changes designed to improve flow and patient experience can add up to big changes in quality and safety
- improvement coaching helps initiate and embed quality improvement work beyond the 'project'-based approach
- building improvement capability ensures quality improvement becomes a sustainable way of working.

For further information please contact:
Steve.Harrison@sth.nhs.uk

Case Study 16

Who
Shrewsbury and Telford Hospital NHS Trust

Programme name
Enhancing continuous learning, quality improvement and innovation

Insight
The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford & Wrekin and mid Wales.

Services are primarily delivered from the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury, which together provide 99% of activity. Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, diagnostics, inpatient medical care and critical care.

In September 2015 the Trust embarked on an extremely exciting programme of work in partnership with the Virginia Mason Institute (VMI) in Seattle and NHS Improvement to embed a lean management method across the organisation and deliver large-scale organisational cultural change.

A core principle of the programme is to enhance the opportunity for continuous learning, quality improvement and innovation through lean leadership training. Once educated and engaged in the methodology and tools, staff become empowered to apply their learning within their own work areas.

What was the aim?

The aim was to:

- Educate c. 500 staff in the methodology, philosophy and management concepts of the Transforming Care Production System (TCPS) within five years and;
- To support a minimum of 2000 staff to engage with and use the TCPS concepts within their areas of responsibility and/or influence to reduce waste and enhance patient and staff satisfaction and experience.

The 'production system' approach taught in TCPS compliments the values already held in the Trust. These are;

- proud to care
- together we achieve
- make it happen
- we value respect.

The approach also provides a renewed focus on the need for constant commitment to quality of care sustained by concentration on learning, quality improvement and innovation.

What did they do?

With a starting point of little lean knowledge within the Trust, a partnership was established with the Virginia Mason Institute with support from NHS Improvement, and a Kaizen (continuous improvement) Promotion Office, (KPO), was set up.

Lean for Leaders is a core element of the training delivered by the KPO team. Leaders from a cross section of the Trust completed prescribed pre-reading, attended the sessions to gain knowledge in:

- the philosophy of respect,
- technical skills including the reduction of waste,
- mistake proofing,
- organising the environment and
- a world class management approach.

One major difference from other leadership development programmes is the requirement for the Lean Leaders to continue to use the lean approaches in practical applications to maintain and improve the performance of their teams and departments.

We encourage our Lean Leaders to consider themselves as coaches and part of the Transforming Care community, embedding improvement and cultural changes within the Trust.

What are the outcomes?

One in five of all the staff who are engaged and using the concepts of TCPS now has Lean Leadership capability. They act as champions who encourage team members to undertake training and participation in events.

Equally importantly they are our 'test-stormers', not just generating ideas for improvements but testing them through rapid cycles of plan, do, study, act (PDSA). Not only do Lean Leaders identify and remove waste from their processes, but importantly they help "join the dots" between the organisation's vision and values and the daily priorities of all their team members, using visual controls and communication boards.

As a trust we seeing the green shoots of cultural shift; the 2017 staff survey showed that the percentage of staff who report "being able to contribute to improvement at work "has risen from 66% in 2015 to 70% in 2017 .

As we approach the end of our second year we are on course to exceed the 2000 staff educated in TCPS to at least "awareness" level, having received 30 minutes or more exposure to the concepts (Figure 1).

In the first two years we will have met the five year target to have 500 staff using the methodology (Figure 2).

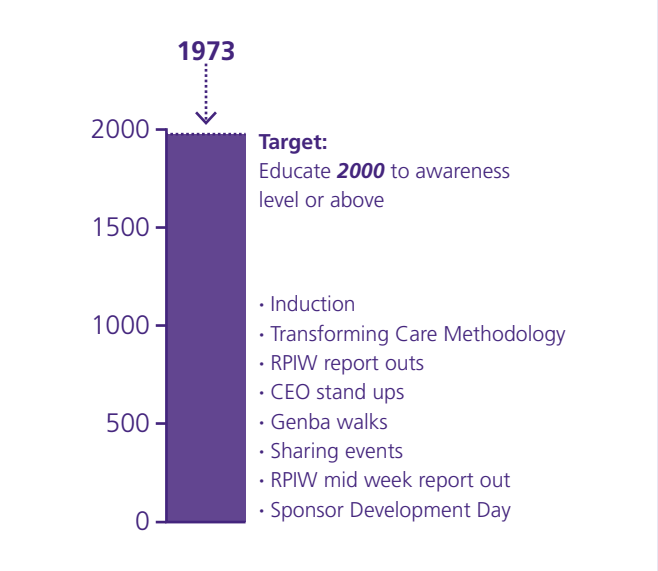


Figure 1: Staff educated in TCPS in first 2 years of transformation programme

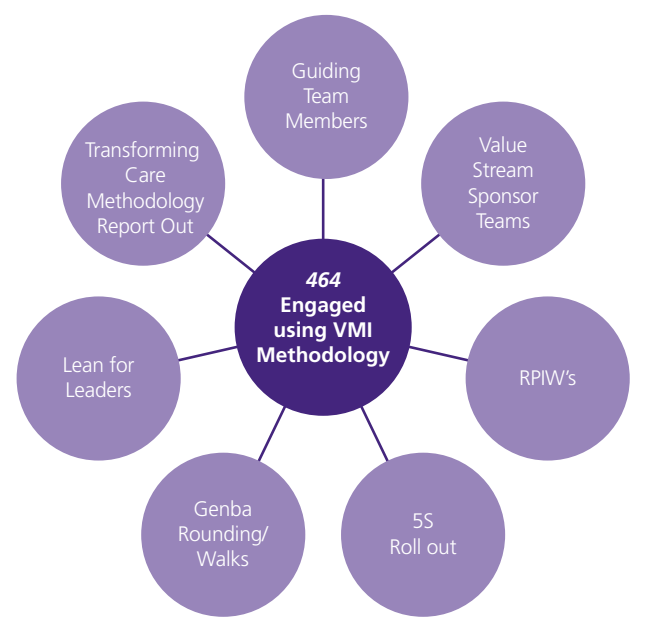


Figure 2: Number of Staff using the TCPS concepts. (Within the first 2 years of the transformation programme).

"The first Lean Leaders undertook their own transformational journey whilst the KPO team, executives and organisation were still assessing what VMI and a lean production system could offer health care in Shropshire. "Although the course has been really tough, especially the homework, it has really helped improve my department's effectiveness and my personal leadership style has changed……. Personally I am spending more time out of the office and on the different genbas, [work areas] this has helped my understanding of the challenges, and also helped with the interaction between myself and the team… ". Paula Davies, Procurement Manager

What is the learning?

Several key ingredients have increased the chances of our Lean Leaders training leading to enhanced leadership and team performance. They include but are not limited to:

- having access to external expertise, developing internal experts
- having a CEO and Trust board who have committed support for a long term transformation programme, who demonstrate this through their behaviours, vocal support and visible participation
- having appropriate resources to enable leader participation, a focus on sustaining activities and spread such as executive genba rounds (where the executives walk the floor and talk to staff) designed to develop people
- attention to maintaining accountability for the consistent delivery and participation in continuous improvement activities
- fully functioning and present leaders, demonstrating the right behaviours, and able to hold their teams accountable for maintaining standards and improvements.

For further information please contact: Cathy Smith KPO Lead Transforming Care Institute SATH - cathy.smith@sath.nhs.uk

NHS Improvement

- Strategic recruitment for diverse teams
- Selection for team orientation
- Selection for team leadership capability
- Leaders developing leaders
- Executive team development
- Team leadership training
- Teamwork training
- Team-based appraisal
- Shared leadership in teams
- Ensuring clarity of team roles
- Team reflexivity and after-action reviews
- Building team-based working
- System leadership

Strategic recruitment for diverse teams

Teams need to be diverse to perform well – not just in their demographics but in skills and experience. So in a sector that depends on effective teamwork, organisations must recruit for optimum diversity.

What is this?

Making sure organisations recruit in ways that ensure appropriate diversity is extremely important, for performance and moral reasons alike. But it is not enough simply to ensure that recruitment and selection are appropriate. We may have a workforce that mirrors the community it serves, but many teams within the organisation may still be inappropriately homogenous. For example, a hospital executive team may be made up entirely or largely of men, in a workforce where women constitute the large majority.

Strategic recruitment for diverse teams aims to ensure that at team level (particularly, senior team level), the degree of diversity is appropriate. This is not only an issue of demography: it addresses questions such as how similar to, or different from, each other team members should be.

Why is this important?

Because teamworking is so important to healthcare delivery and organisational performance, it is vital to think carefully about constructing teams. Usually, teams must be diverse to perform effectively (for example, in delivering high quality, continually improving and compassionate care), in relation to:

- function
- knowledge
- experience
- skills
- demographic characteristics.

So recruitment processes must be designed to achieve appropriate diversity in teams.

An organisation creates a team because a task requires people to work interdependently together. This implies that team members must, between them, have the necessary diversity of knowledge, skills, abilities and experience to achieve their shared goal. So an executive team in a trust would include leaders in a range of fields, such as care quality, finance, people management, operations and estates.

Similarly, we need to secure a wide range of experience and orientations for effective decision-making and performance.

The key issue facing the NHS in relation to diversity is the high levels of discrimination experienced by staff. So this is the most important issue to address in relation to strategic recruitment for diverse teams. The simple prescription is to set targets to ensure appropriate representation of discriminated-against groups in all senior teams within three to five years.

What is the evidence?

If all team members have similar backgrounds, views, experiences and values, they are likely to quickly establish good relationships and work reasonably effectively as a team.

Conversely, where team members are dissimilar, they are likely to find that early interactions are characterised by conflict as members try to understand each other and agree the objectives, leadership and roles in the team.

This might sound like a prescription for keeping teams as homogenous as possible. However, over time, a greater diversity of perspectives will offer a broad range of views and knowledge. This in turn produces better decision-making, more innovation and higher levels of effectiveness (Guillaume et al 2014, Van Knippenburg and Schippers 2007, Van Knippenburg et al 2004, 2007). This synergy is achieved by making a conscious effort to ensure effective, integrated teamworking.

Innovation and performance

Groups of people with differing professional backgrounds, knowledge, skills and abilities are more innovative than those whose members are similar, because they bring usefully differing perspectives on issues to the group (Paulus 2000). Their divergent views offer multiple perspectives and the potential for constructive debate.

Diversity also contributes to the pool of task-related skills, information and experience. If teams work through their differences in information and perspectives constructively and compassionately, they are much more effective and innovative (Tjosvold 1998, Paulus 2000). For example, in a study of 100 primary healthcare teams, Borrill et al (2000) found that the more professional groups represented in the team, the more innovation in patient care. Groups that contain people with diverse and overlapping knowledge domains and skills are particularly creative.

Diversity of functional backgrounds also influences team performance. The greater a team's functional diversity, the more its members communicate and work outside the team's boundaries, and the higher their levels of innovation (Edmondson and Nembhard 2009).

An asset-based approach

Diversity translates into effectiveness and innovation when team members manage their differences as a valuable asset rather than as a threat to their individual identities (Van Knippenburg and Schippers 2007, West 2002). This means having diversity beliefs or climates of inclusion (Guillaume et al 2014) that focus on the benefits of diversity to team performance.

Leaders can increase the benefits of diversity while reducing the disadvantages by encouraging all team members to appreciate its benefits for team functioning (Van Knippenburg and Schippers 2007).

Implications for strategic recruitment

All this has implications for strategic recruitment for diverse teams.

Mental ability

First, it is important to recruit people with high ability in relation to the team task. For individual jobs, general mental ability is one of the best predictors of job performance (Schmidt and Hunter 1998). Not surprisingly, team members' overall ability predicts team performance. This was demonstrated in one study (Tziner and Eden 1985), which also showed that people of high ability contributed most to performance when all the other team members were also high in ability.

Personality mix

Many NHS organisations focus on personality mix in teams. The Big Five model of personality (Barrick and Mount 1991, Barrick et al 1998) offers a robust personality model that can be used to analyse mix of personality in teams and the effects on team performance. The model describes five dimensions of personality:

O Openness to experience
new ideas, experiences and imaginings

C Conscientiousness
competence, order and self-discipline

E Extraversion
positive emotions, gregariousness and warmth

A Agreeableness
trust, straightforwardness and tender-mindedness

N Neuroticism
anxiety, self-consciousness and vulnerability

Research suggests that teams composed of members with high average levels of openness to experience, conscientiousness, extraversion and agreeableness perform best (Mount et al 1998, Bell 2007). Those with high neuroticism scores also have a value: they are good judges of risk. This can be hugely important in high-risk tasks. Organisations are recommended to use freely available Big Five measures rather than some of the weaker approaches commonly used.

How is it done?

Creating teams involves assembling the range of skills required for the task (Hackman 2002, Wageman et al 2008). It also involves thinking through what types of behaviours, attitudes skills and abilities will be needed for the team to be effective. Prospective team members must be recruited in a way that ensures enough diversity in people's functional backgrounds, life experience, culture and work experience for the team to integrate a variety of perspectives in its work and decision-making.

However, more often teams use the 'attraction, selection, attrition' model (Schneider et al 2000), attracting people similar to existing members. They select these people, and those who are dissimilar are likely to leave the team. Another theory with strong research support shows that we are attracted to those who are similar to us, so we contrive to organise and evaluate our social worlds accordingly (Byrne 1997). Given this, recruitment must deliberately be designed to ensure necessary diversity in teams.

Two types of diversity

Strategic recruitment involves distinguishing between two types of diversity:

- functional diversity such as organisational position or specialised technical knowledge
- relations-oriented diversity such as age, gender, ethnicity, social status and personality.

Functional diversity is reflected in skill mix: the balance between trained and untrained, qualified and unqualified, and supervisory and operative staff in a service area, as well as between different staff groups. Optimum skill mix is achieved when the desired standard of service is provided, at the minimum cost.

Relations-oriented diversity means ensuring that, wherever possible, team members vary by, for example, age, gender and ethnicity. This includes the need for teams to be representative generally of the communities they serve.

Organisations need to develop a recruitment strategy that identifies this distinction, and ensure that the people involved in doing this are aware of the research evidence described above. Selection processes should take account of these issues, and organisations need to monitor the success of their recruitment and selection strategies in delivering team diversity (West and Allen 1998).

It is vital that training for team members and leaders enables everyone to benefit from the synergistic effects of diversity.

Tips

- The first step in this approach is to decide which teams to focus on to ensure appropriate diversity. This is likely to be among the most senior teams in the organisation – perhaps the top 50 to 100.
- To recruit effectively for teams, map them within the organisation and understand their vision, purpose and objectives.
- Build on this analysis with a clear understanding of the skills the team requires and the roles its members must perform.
- Make sure existing team diversity is monitored (for example, looking at gender distribution in the executive team).
- Involve team leaders in discussions focused on ensuring that recruitment and selection provide teams with the appropriate diversity of skills, knowledge and abilities.
- Encourage team leaders and members to discuss regularly whether their teams are sufficiently diverse – particularly in relation to ethnicity, gender, age, disabilities and other demographic characteristics.

See also Team leader training, teamwork training, Inclusion: listening to all voices.

References

Barrick MR, Stewart GL, Neubert MJ, Mount MK (1998) Relating member ability and personality to work-team processes and team effectiveness. *Journal of Applied Psychology* 83: 377–391

Barrick MR, Mount MK (1991) The big five personality dimensions and job performance: a meta-analysis. *Personnel Psychology* 44: 1–26

Belbin RM (2011) Management teams: why they succeed or fail. Human Resource Management International Digest 19 (3). Available at: https://doi.org/10.1108/hrmid.2011.04419cae.002 (accessed 6 August 2017)

Bell ST (2007) Deep-level composition variables as predictors of team performance: a meta-analysis. *Journal of Applied Psychology*. 92: 595–615

Borrill C, West M, Shapiro D, Rees A (2000) Team working and effectiveness in the NHS. *British Journal of Health Care Management* 6: 364–371

Byrne D (1997). An overview (and underview) of research and theory within the attraction paradigm. *Journal of Social and Personal Relationships* 14 (3): 417–431

Edmondson AC, Nembhard IM (2009) Product development and learning in project teams: the challenges are the benefits. *Journal of Product Innovation Management* 26 (2): 123–138

Guillaume YRF, Dawson JF, Priola V, Sacramento CA, Woods SA, Higson HE, Budhwar PS, West MA (2014) Managing diversity in organizations: an integrative model and agenda for future research. *European Journal of Work and Organizational Psychology* 23 (5): 783–802

Hackman JR (2002) Leading teams: setting the stage for great performances. Harvard Business School Press, Boston

Hill GW (1982) Group versus individual performance: are N+1 heads better than one? *Psychological Bulletin* 91 (3): 517–539

Mount MK, Barrick MR, Stewart GL (1998) Five-factor model of personality and performance in jobs involving interpersonal interactions. *Human Performance* 11: 145–165

Paulus PB (2000) Groups, teams and creativity: the creative potential of idea-generating groups. Applied Psychology: *An International Review* 49: 237–262

Schmidt F, Hunter J (1998) The validity and utility of selection methods in personnel psychology: practical and theoretical implications of 85 years of research findings. *Psychological Bulletin* 124: 262–274

Schneider B, Smith DB, Goldstein HW (2000). Attraction–selection–attrition: toward a person–environment psychology of organizations. Lawrence Erlbaum Associates Publishers, Mahwah NJ

Schutz WC (1967) The FIRO scales. Consulting Psychologists Press, San Francisco CA

Tjosvold D (1998) Co-operative and competitive goal approaches to conflict: accomplishments and challenges. *Applied Psychology: An International Review* 47: 285–342

Tziner A, Eden D (1985) Effects of crew composition on crew performance: does the whole equal the sum of its parts? *Journal of Applied Psychology* 70: 85–93

Van Knippenberg DV, De Dreu C KW, Homan AC (2004) Work group diversity and group performance: an integrative model and research agenda. *Journal of Applied Psychology* 89: 1008–1022

Van Knippenberg D, Haslam SA, Platow MJ (2007) Unity through diversity: value-in-diversity beliefs as moderator of the relationship between work group diversity and group identification. *Group Dynamics: Theory, Research and Practice* 11: 207–222

Van Knippenburg D, Schippers MC (2007) Work group diversity. *Annual Review of Psychology* 58: 515–541

Wageman R, Nunes DA, Burruss JA, Hackman JR (2008) Senior leadership teams: what it takes to make them great. Harvard Business School Press, Boston

West MA, Allen NA (1997) Selection for teamwork In Anderson N, Herriot P (eds) International handbook of selection and assessment. John Wiley and Sons, Chichester: 493–506

West MA (2002) Sparkling fountains or stagnant ponds: an integrative model of creativity and innovation implementation in work groups. *Applied Psychology: An International Review* 51 (3): 355–387

Selection for team orientation

High quality healthcare depends on good teamworking. These skills can be learned, but it helps to recruit people who are already oriented towards this style of working.

What is it?

If an organisation is to have effective team-based working, it needs to make sure staff are motivated and skilled to work in teams.

Selection for team orientation involves building into selection processes methods that provide information about people's knowledge, skills, abilities and motivations to work in teams. If it identifies people with a strong team orientation, you may choose to give preference to those candidates. If it identifies a learning need, it is useful to know that this needs to be addressed.

Selecting people with a high team orientation will lead to better team performance. However, team orientation can also be developed through effective leadership and training. So selecting team leaders who have the commitment to building an effective team is important.

Someone's orientation towards teamworking might include factors such as:

- a collective, rather than individualistic, approach to working with others
- social skills such as listening, speaking, and co-operating
- teamworking skills such as collaboration, concern for the team and interpersonal awareness.

Social skills for good teamworking

Active listening skills – listening to what other people are saying and asking questions

Communication skills – planning how to communicate effectively taking into account the receiver, the message and the medium

Social perceptiveness – being aware of others' reactions and understanding why they react the way they do

Self-monitoring – being sensitive to the effects of our behaviour on others

Altruism – working to help colleagues

Warmth – positivity and co-operation

Patience and tolerance – accepting criticism and dealing patiently with frustrations

Source: Peterson et al (2001)

Why is this important?

The NHS relies on effective teamworking. In turn, teamworking is strongly associated with high quality patient care. However, despite this, most NHS teams appear to be 'pseudo-teams', where individuals do not co-ordinate their work as effectively as possible, are often unclear about one another's roles and are not focused on clear, challenging interdependent team goals or objectives (Lyubovnikova et al 2015).

Research (Lyubovnikova and West 2013, West and Markiewicz 2016, Giessner et al 2013) shows that teams perform better when team members emphasise these features:

- interdependent goals
- a cohesive approach
- supportive, effective conflict resolution
- commitment to building group trust and co-operation
- learning from errors
- knowledge sharing
- flexibility of approaches to work
- sacrificing one's own time for the team
- valuing fairness and equality
- greater commitment to team goals than personal goals
- good communication
- goal setting and performance management
- planning and co-ordination
- collaborative problem solving.

What is the evidence?

Stevens and Campion (1994, 1999) propose that effective team functioning depends on teamwork knowledge, skills and abilities. They divided these into two broad areas: interpersonal and self-management. In several studies, they found that team members' scores related significantly to their teams' performance.

Tip: Create teams with key knowledge, skills and abilities

Stevens and Campion's results tell us that we should be creating teams of people who have all, or most of, the knowledge, skills and abilities the authors describe, and/or train all team members to develop these qualities. Find out more in How is it done?

A range of evidence shows the links between high team orientation and performance, and identifies leadership qualities that increase team orientation:

- Driskell et al (2010) found that higher team orientation scores were strongly associated with effective team performance in decision-making, negotiating and task execution. You can try their questionnaire at the end of this section.
- A study by Mohammed and Angell (2004) explored the role of team orientation in neutralising team interpersonal conflict. The findings demonstrate that team orientation helps to reduce the negative effects of team conflict, which in turn affects team performance.
- Lord and Brown (2004) examined team leaders' role in shaping the collective identity of individuals within a team. They found that teams with transformational versus transactional leadership had more team-oriented values.
- De Cremer and van Knippenberg (2002) found that teams with leaders who modelled self-sacrificing behaviours were more likely to co-operate, share resources and feel pride and belonging within the team.

How is it done?

One way to select for team orientation and team knowledge, skills and abilities is to use standardised questionnaires. This section presents two approaches, by Driskell et al (2010) and Stevens and Campion (1999) respectively.

Team orientation measures

This measure, developed by Driskell et al (2010), has strong reliability and validity. It focuses on the extent to which people are comfortable with, and motivated by, working in a team.

Using this scale, the authors and other researchers found that higher team orientation scores were strongly associated with effective team performance in decision-making, negotiating and task execution.

Link to this tool

Knowledge, skills and abilities for teamwork

Another approach focuses less on personality and more on the ingredients required for teamwork. The following measure, adapted from Stevens and Campion (1994, 1999), offers a simple way of assessing knowledge, skills and abilities for teamwork (see West 2012 for more details).

Using these measures, or adapting them for use in situational judgement tests, (McDaniel et al 2001) provides a simple approach to selecting for team orientation and knowledge, skills or abilities. The content also provides guidance about what skills need to be developed in staff for effective teamworking.

Link to this tool

Team orientation scale

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I find working on team projects to be very satisfying.	○	○	○	○	○
I would rather take action on my own than to wait around for others' input.*	○	○	○	○	○
I prefer to complete a task from beginning to end with no assistance from others.*	○	○	○	○	○
Teams usually work very effectively.	○	○	○	○	○
I think it is usually better to take the bull by the horns and do something yourself, rather than wait to get input from others.*	○	○	○	○	○
For most tasks, I would rather work alone than as part of a group.*	○	○	○	○	○
I find it easy to negotiate with others who hold a different viewpoint than I hold.	○	○	○	○	○
I can usually perform better when I work on my own.*	○	○	○	○	○
I always ask for information from others before making any important decision.	○	○	○	○	○
I find that it is often more productive to work on my own than with others.*	○	○	○	○	○
When solving a problem, it is very important to make your own decision and stick by it.*	○	○	○	○	○
When I disagree with other team members, I tend to go with my own gut feelings.*	○	○	○	○	○
When I have a different opinion than another group member, I usually try to stick with my own opinion.*	○	○	○	○	○
It is important to stick to your own decisions, even when others around you are trying to get you to change.*	○	○	○	○	○
When others disagree, it is important to hold one's own ground and not give in.*	○	○	○	○	○

*These items are reverse scored.

Scoring: Answers are given on a scale ranging from 1 strongly disagree; 2 disagree; 3 neither agree nor disagree; 4 agree; to 5 strongly agree. For reverse-scored items, a score of 5 is reversed to a 1, a score of 4 reversed to a 2 and a score of 3 stays the same. Individuals' scores are totalled to give an overall indication of team orientation.

Source: Driskell et al (2010)

Knowledge, skills and abilities for teamwork

This questionnaire is designed for self-completion or completion by fellow team members.

		Very little						A great deal
Communication	I understand and use communication networks – making sufficient contact with colleagues	1	2	3	4	5	6	7
	I communicate openly and supportively	1	2	3	4	5	6	7
	I listen actively and non-evaluatively	1	2	3	4	5	6	7
	There is a consistency between my verbal and non-verbal behaviour	1	2	3	4	5	6	7
	I value and offer warm greetings and small talk with colleagues	1	2	3	4	5	6	7
Goal setting & performance management	I help establish clear and challenging team goals	1	2	3	4	5	6	7
	I monitor and give supportive feedback on team and individual performance	1	2	3	4	5	6	7
Planning and co-ordination	I help to co-ordinate activities, information and working together between members	1	2	3	4	5	6	7
	I help to clarify tasks and roles of team members and ensure balance of workloads	1	2	3	4	5	6	7
	I respond positively and flexibly to feedback from team members	1	2	3	4	5	6	7
Collaborative problem-solving	I identify problems requiring participation of all team members in decision-making	1	2	3	4	5	6	7
	I use appropriate ways of involving team members in decision-making	1	2	3	4	5	6	7
	I explore and support proposals for innovation in the team	1	2	3	4	5	6	7
Conflict resolution	I discourage undesirable conflict	1	2	3	4	5	6	7
	I employ win-win rather than win-lose negotiation strategies	1	2	3	4	5	6	7
	I recognise types and sources of conflict and implement appropriate conflict resolution and reduction strategies	1	2	3	4	5	6	7

Adapted from Stevens and Campion (1999)

References

De Cremer D, Van Knippenberg D (2002) How do leaders promote cooperation? The effects of charisma and procedural fairness. *Journal of Applied Psychology* 87 (5): 858

Driskell JE, Salas E, Hughes S (2010) Collective orientation and team performance: development of an Individual Differences Measure. *Human Factors* 52 (2): 316–328

Giessner SR, van Knippenberg D, van Ginkel W, Sleebos E (2013) Team-oriented leadership: the interactive effects of leader group prototypicality, accountability, and team identification. *Journal of Applied Psychology* 98 (4): 658

Lord RG, Brown DJ (2004) *Leadership processes and follower self-identity.* Erlbaum, Mahwah NJ

Lyubovnikova J, West MA (2013). Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas E, Tannembaum SI, Cohen D, Latham G (eds). Developing and enhancing teamwork in organizations. Jossey Bass, San Francisco CA: 331–372

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of work and Organizational Psychology* 24 (6): 929–950

McDaniel MA, Morgeson FP, Finnegan EB, Campion MA, Braverman EP (2001) Use of situational judgment tests to predict job performance: a clarification of the literature. *Journal of Applied Psychology* 86: 730–740.

Peterson NG, Mumford MD, Borman WC (2001) Understanding work using the occupational information network (ONET): implications for practice and research. *Personnel Psychology* 54: 451–492

Stevens MJ, Campion MA (1999) Staffing work teams: development and validation of a selection test for teamwork settings. *Journal of Management* 25: 207–228

Stevens MJ, Campion MA (1994) The knowledge, skill, and ability requirements for teamwork: implications for human resource management. *Journal of Management* 20: 503–530

West MA (2012) Effective teamwork: practical lessons from organizational research. Third edition. Blackwell, Oxford

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

Selection for team leadership capability

Being an effective team leader requires different skills from other types of leadership. If an organisation wants effective teamworking, it is worth assessing for these qualities as part of the selection process.

What is it?

Strong team leadership skills are vital for good team performance. So organisations need to focus on selecting people with the knowledge, skills, abilities and values for teamwork in general, and for leading teams in particular. They also need to support team leaders to continue developing their team leadership skills.

Selecting for team leadership involves understanding what the knowledge, skills and abilities for team leadership are, and then recruiting and selecting accordingly.

See also Teamwork training and Team leadership training.

Why is this important?

Researchers have consistently pointed to the importance of leadership in determining teams' effectiveness over the last 10 years. However, in health services, leadership is often poor (Øvretveit et al 2002, Plsek and Wilson 2001).

Leadership in health services is important not just at the organisational level, but at the team level too (Buttigieg and West 2013). Leadership style has been associated with quality of care, clinical governance and patient complaints (Shipton et al 2008). A large-scale study of leadership in NHS teams (West et al 2003) revealed that leadership clarity was associated with clear team objectives, high levels of participation, commitment to excellence and support for innovation. These team processes consistently predicted team innovation across all three samples. Where there was conflict about leadership within the team, team processes and outcomes were poor.

Only one-third of primary healthcare teams and one-tenth of community mental health teams reported having a single clear leader, and in nearly half of primary healthcare teams, members reported that several people led the team. Lack of clear leadership predicted higher stress levels among team members. Such conflict and lack of clarity are partly a result of appointing people to team leadership roles who do not have the necessary knowledge, skills, abilities or values. So it is important to select team leaders with the right attributes, to ensure teams are well-led in healthcare organisations.

What is the evidence?

Traditional leaders tend to be directive rather than facilitative and advice-giving rather than advice-seeking. They seek to determine rather than integrate views. In contrast, effective team leaders share responsibility for the team and encourage team members to take responsibility when things are not going well. They are less likely to exercise control over the final choice when decisions need to be made, and they tend to manage the team as a whole, as well as supporting individual team members (Pearce and Conger 2002).

In a meta-analysis of 42 independent studies, Wang et al (2014) examined the 'sharedness' of leadership processes in teams (which they defined as shared leadership, collective leadership and distributed leadership). Shared team leadership was powerfully associated with team effectiveness. It also affected team climate, behaviours and team optimism and potency. This is particularly true when the work is relatively complex, as is generally the case for healthcare teams. So it is important to select team leaders who are skilled at encouraging and facilitating shared team leadership.

The research evidence also points to the importance of transformational team leadership in predicting team performance (Judge and Piccolo 2004). These leaders influenced the team through their inspirational motivation, intellectual stimulation and attention to each individual's needs. This type of leadership brings shared vision, team commitment, an empowered team environment and helpful rather than destructive team conflict. In turn, these affect team innovation, communication, cohesion and conflict management (Eisenbeiss et al 2008, Plsek 2013, Dionne et al 2004, Sivasubramaniam et al 2002, West 2012).

In one study (Özaralli 2003), employees from various industries rated their superiors' transformational leadership and how much they felt empowered. They evaluated their teams' effectiveness in terms of innovation, communication and team performance. Findings showed that transformational leadership is related to team leaders' empowerment and that the more empowered the team, the more effective it will be. So selecting for transformational leadership qualities makes sense.

So too does selecting for emotional intelligence. Another study (Elisabeth and Wolff 2008) demonstrated the importance of links between emotional intelligence in team leaders, emotional intelligence at team level and team performance. The research showed that emotional intelligence in team leaders is significantly related to team processes and climate – which, in turn, are related to team performance.

How is it done?

Selecting for team leaders means seeking the knowledge, skills and abilities that are core to team leadership. This can be done via a structured interview, using standardised questionnaires (for example, to assess transformational leadership and emotional intelligence). But it can also be based on the reports of those who work in teams with target individuals. The following list shows key attributes to seek when selecting team leaders.

Key attributes in team leaders

Team leadership style

- Compassionate leadership: attending, understanding, empathising, helping
- Facilitative, supportive leadership style
- Positive, optimistic orientation
- Well-developed coaching skills.

Skilled in managing team processes

- Offering inspiring vision and clear direction
- Team orientation
- Understanding the principles of effective teamwork
- Effective at setting up and ensuring regular, productive and positive team meetings
- Encouraging positive, supportive, cohesive relationships within the team.

Skills in managing diversity

- Capacity to integrate team members' divergent views
- Positive orientation to diversity: valuing diversity whether in relation to professional groups, demography or opinion
- Listening with respect and fascination to all voices.

Conflict management skills

- Effective in preventing and resolving intense conflicts within teams
- Good inter-team conflict management skills based on a well-established model.

Leading for quality improvement and innovation

- Skills for encouraging, supporting and leading innovation
- Effective at nurturing team learning and quality improvement
- Track record of encouraging reflexivity and learning from errors.

Organisational skills

- Effective in managing organisational politics and in winning resources
- A strong track record of, or commitment to, leading inter-team co-operation.

References

Buttigieg SC, West MA (2013) Senior management leadership, social support, job design and stressor-to-strain relationships in hospital practice. *Journal of Health Organization and Management* 27 (2): 171–192

Dionne SD, Yammarino FJ, Atwater LE, Spangler WD (2004) Transformational leadership and team performance. *Journal of Organizational Change Management* 17 (2): 177–193

Eisenbeiss SA, van Knippenberg D, Boerner S (2008) Transformational leadership and team innovation: Integrating team climate principles. *Journal of Applied Psychology* 93 (6): 1438–1446

Elizabeth SK, Wolff SB (2008) Emotional intelligence competencies in the team and team leader. *The Journal of Management Development* 27 (1): 55–75

Judge TA, Piccolo RF (2004) Transformational and transactional leadership: a meta-analytic test of their relative validity. *Journal of Applied Psychology* 89 (5): 755–768

Øvretveit J, Bate P, Cleary P, Cretin S, Gustafson D, McInnes K, Shortell S (2002) Quality collaboratives: lessons from research. *Quality and Safety in Health Care* 11 (4): 345–351

Özaralli N (2003) Effects of transformational leadership on empowerment and team effectiveness. *Leadership, Organization Development Journal* 24 (6): 335–344

Pearce CL, Conger JA (2002) Shared leadership: reframing the hows and whys of leadership. Sage, London

Plsek PE (2013) Accelerating health care transformation with lean and innovation: the Virginia Mason experience. CRC Press, Boca Raton FL

Plsek PE, Wilson T (2001) Complexity science: complexity, leadership and management in healthcare organisations. *British Medical Journal* 323 (7315): 746

Shipton H, Armstrong C, West M, Dawson J (2008) The impact of leadership and quality climate on hospital performance. *International Journal for Quality in Health Care* 20 (6): 439–445

Sivasubramaniam N, Murry WD, Avolio BJ, Jung DI (2002) A longitudinal model of the effects of team leadership and group potency on group performance. *Group, Organization Management* 27(1): 66–96

Wang D, Waldman DA, Zhang Z (2014) A meta-analysis of shared leadership and team effectiveness. *Journal of Applied Psychology* 99 (2): 181–198

West MA (2012) *Effective teamwork: practical lessons from organizational research.* John Wiley and Sons, Chichester

West MA, Borrill CS, Dawson JF, Brodbeck F, Shapiro DA, Haward B (2003) Leadership clarity and team innovation in health care. *The Leadership Quarterly* 14 (4): 393–410

Leaders developing leaders

Encouraging senior leaders to act as mentors, role models and coaches is an effective way of supporting emerging talent and opening dialogue between senior leaders and their junior colleagues.

What is it?

Leaders developing leaders is a practice that focuses on using experienced leaders as in-house coaches, trainers and teachers in their own organisations to develop other leaders.

Why is this important?

Seasoned leaders (including those in non-leadership roles but with experience in the organisation) are uniquely positioned to role-model and share the leadership values, beliefs and behaviours that are important to develop in their organisation.

To be effective and efficient, initiatives to build a leadership pipeline (addressing core aspects of succession planning) need to develop not only leadership skills but an interconnected cadre of leaders with similar mindsets and values. The organisation benefits from a strengthened culture of learning and continuous development, laying a solid foundation for organisational innovation and quality improvement (DeSmet and McAlpine2010).

What is the evidence?

Leadership development is a fundamental process that goes much deeper than simply building certain skills. It entails developing values, mindsets and even identities. In particular, the dynamics around identity are based on social interactions with senior leaders. This involves helping new talent to adopt an emerging leader identity, which then takes shape through the individual's relationships with followers, and becomes reinforced through their recognition from others (DeRue and Ashford 2011, Kempster and Steward 2010).

Evolving from a junior to a senior leader involves not only increasing one's skill, but developing qualitatively different skills and perspectives. It is a journey based on developing identity, self-awareness and emotion regulation. These can be learned more meaningfully if they are demonstrated and supported by senior leaders as role models, coaches and mentors (Lord and Hall 2005). It is also a way to ensure learning stays grounded in reality and can be applied in practice (Conger 2010).

Research by the Center for Creative Leadership shows that high-performing companies have leaders who lead purposefully, to increase engagement, diversity and accountability (Van Velsor et al 2010).

Among these companies, a core leadership task is to develop other leaders through role modelling, teaching, coaching, mentoring, and active dialogue and reflection around the topic of leadership. They hold their leaders accountable for the promotion rate of people with high potential, have fully integrated diversity and inclusion goals for selecting and developing leaders, and have an overall mindset of leaders needing to connect with people and mobilise the talent of tomorrow (Cacioppe 1998, Cohen and Tichy 1997).

How is it done?

Leaders developing leaders is a concept that can be implemented across the elements of talent management practice:

Selection and promotion

Leaders are held accountable for identifying those with high potential and new leadership talent. They are not only involved in these processes but lead them, and are accountable for making sure the selection specifications and promotion criteria enable the right kind of leadership talent to be selected and promoted.

Organisations that do this well select senior leaders for their ability to develop other leaders, based on their track record of championing leadership talent (Van Velsor et al 2010).

Leadership development

Most top companies for leadership consider leadership development to happen in formal and informal settings, such as the 70-20-10 model (Van Velsor et al 2010). This model, developed by the Center for Creative Leadership, emerged from 30 years of research into how leaders learn over the course of their careers. It found that leaders learned from three types of experience: challenging assignments (70% of the learning), developmental relationships (20%) and coursework and training (10%).

They foster relationships and networking among leaders by establishing buddying systems, peer coaching and mentoring programmes, as well as regular meetings and networking events among leaders on the same level and across different levels. They integrate leader-led development in formal programmes – for example, through chats, executive speeches and panel debates, as well as formal mentoring programmes.

Reward and recognition

Organisations can engage future leaders by emphasising that leadership is learnable and teachable, and rewarding current leaders for role-modelling this belief. This can be described as a developmental mindset: coaching others to succeed and realise their potential, and enhancing team member performance rather than focusing on personal achievement (Gentry 2016).

Organisations can promote this approach through formal recognition, such as organisational mentorship awards, as well as informal recognition, such as by earning a reputation for being a good talent developer, coach or mentor. In particular, internal communications can help nurture a culture of leaders developing leaders by regularly portraying stories and successes, as well as acknowledging the role of mentors and internal coaches in formal development processes.

Goals and performance

Senior leaders' feedback boosts the value of experiential learning – it reinforces new skills, refines insights and challenges junior leaders to stretch themselves further (DeRue, Wellman 2009).

Managing succession

For an intact and up-to-date succession pipeline, leaders need to continuously develop those who could grow to replace them. If leaders are to develop themselves so that they appreciate the benefits of developing and helping others to grow, they must have a developmental mindset and self-efficacy. Top companies hold their leaders accountable for developing their successors, and include this point in their annual performance review process.

The practice of leaders developing leaders reaches far beyond formal learning: it particularly targets informal learning and enables others to gain insight from reflecting on their own experience. Leaders who drive others to reflect on their own

experience turn routine meetings into interactions rich in learning. If they exude a tone of inquiry and discovery, they are an important everyday resource that the organisation can tap into at almost no extra cost (Spear 2015).

Tips

- Leader-led development can help in various areas – for example, illustrating how skills-based training content relates to the organisational purpose, how it can be applied and why it is relevant.
- Help senior leaders create a teachable point of view (Tichy 1997). This involves enabling them to tell their own stories in an insightful and engaging way. Not everyone is a natural storyteller. It is highly recommended that development professionals invest time working with leaders upfront and coaching them, on the content of their message, as well as how they deliver it.
- Position this work as a two-way learning process. Role-modelling a developmental mindset involves listening, not just telling. So leaders need to structure their involvement to balance their input with an open discussion with the audience. This makes the insights richer and the overall experience more rewarding and insightful for leaders and learners alike. Communicating directly with new generations has significant value for senior leaders, as they gather insights on what is happening at the front line of service delivery. This is 'direct news' that might otherwise not reach them.
- Sometimes leaders state they have no time to engage in such events. It helps to ask them to join 'just for five minutes' to quickly tell an anecdote about their experience with a certain topic. Very often, they stay longer.

References

Cacioppe R (1998) Leaders developing leaders: an effective way to enhance leadership development programs. *Leadership and Organization Development Journal* 19 (4): 194–198

Cohen E, Tichy N (1997) How leaders develop leaders. *Training and Development May*: 58

Conger J (2010) Leadership development programs: return on investment In Nohria N, Khurana R (eds) *Handbook of leadership theory and practice.* Harvard Business School Publishing, Boston: 709–738

DeRue DS, Ashford SJ (2011) Who will lead and who will follow? A social process of leadership identity construction in organizations. *Academy of Management Review* 35 (4): 627–647

DeRue DS, Wellman N (2009) Developing leaders via experience: the role of developmental challenge, learning orientation, and feedback availability. *Journal of Applied Psychology* 94 (4): 859–875

DeSmet J, McAlpine C (2010) *Tapping the inner teacher: delivering high-impact learning through leader-led development.* White paper. Harvard Business School, Boston

Gentry WA (2016) Be the boss everyone wants to work for: a guide for new leaders. Jossey-Bass, San Francisco CA

Kempster S, Stewart J (2010) Becoming a leader: a co-produced autoethnographic exploration of situated learning of leadership practice. *Management Learning*, 41 (2): 205–219

Lord RT, Hall RJ (2005) Identity, deep structure and the development of leadership skill. *Leadership Quarterly* 16: 591–615

Spear S (2015) Leader-led learning: the great differentiator. Blog post from Sloan Management's Innovation@Work. Available at http://executive.mit.edu/blog/leader-led-learning-the-great-differentiator (accessed 14 March 12017)

Tichy N (1997) The leadership engine: how winning companies build leaders at every level. HarperCollins, New York

Van Velsor E, McCauley CD, Ruderman MN (2010) Handbook of leadership development. The Center for Creative Leadership/Jossey-Bass-Wiley, San Francisco, CA

Executive team development

The executive team is the foundation on which the rest of the organisational culture is built. But a high-functioning senior team does not emerge naturally: it must develop specific skills with an eye on the strategic vision.

What is this?

Executive team development involves supporting an organisation's executive (or 'senior') team to function effectively.

It involves making sure the senior team works as a real team towards clear, shared objectives, rather than simply as a group of individuals representing different functional areas. In particular, it focuses on:

- team structure – ensuring the right purpose and the right membership for the purpose
- team processes – team member participation, managing conflict, learning and innovation, and supporting innovation.

Senior team development interventions also ensure that relationships help the team to function effectively, creating a climate of cohesion, optimism and efficacy.

Why is this important?

The senior team plays a vital and pervasive role in determining an NHS organisation's effectiveness. Together its members decide strategy, shape the culture, scan the environment, monitor performance and, above all, support the organisation in pursuing its aims and achieving its vision. So it is essential that it functions as well as it can.

The senior team is usually made up of those who have risen or fought their way to the top of their particular specialist areas. Precisely because of this individualism, bringing them together to work in a team can produce a competitive and dysfunctional group rather than a co-operative, integrated and supportive team (Flood et al 2001).

Many senior management teams fail to perform as teams for one simple reason: they have not identified what they need to work on together as a team. They may assume their tasks are simply to fulfil their functional areas' objectives. But this type of silo working can create the opposite of synergy, with members competing for resources and undermining each other rather than committing to the success of the team and organisation as a whole.

The effects of this dissonance can undermine integrated collaborative working and the climate across the whole organisation. Farrell et al (2005) and MacCurtain et al (2010) found that the more positive the senior team climate, and the greater the trust between senior team members, the more employees saw the climate as supportive and encouraging innovation and experimentation (see also Albrecht and Travaglione 2003).

What is the evidence?

Executive team development must focus on team structure (including the team's 'task' or purpose and membership), processes and relationships. This section addresses each in turn.

Team structure

An executive team's overall purpose is to take responsibility for direction, alignment and commitment in the organisation (Drath et al 2008).

Many senior management teams mistakenly assume the organisation's objectives and those of the senior team are the same. This results in the senior team (Flood et al 2001):

- having over-large agendas
- being drawn in too many directions
- offering only superficial input in important areas
- interfering inappropriately in operational activities in other areas
- failing to achieve a clear sense of purpose that unites the team and capitalises on their interdependent working.

A study of 120 senior management teams around the world showed that chief executives over-challenged individual members but under-challenged the team, resulting in team members neglecting senior team work and focusing their energies on their individual areas (Wageman et al 2008). Instead, senior team members should be involved primarily in:

- exchanging strategic information – sharing knowledge about regulators' actions, legislative changes and shifts in demand
- co-ordinating organisational initiatives – ensuring all staff have effective appraisals and high quality first line supervision, or implementing team-based working across the organisation
- making vital decisions on the organisation's behalf – deciding on new services, merging or partnering with other organisations or implementing new leadership strategies.

Like a team at any other level, once the senior team identifies its appropriate purpose, it needs to set its objectives. These must be clear, challenging and few in number – no more than about six to eight (Locke and Latham 2013).

Wageman et al (2008) found that in many senior teams, members did not share a common understanding of the organisation's strategy – even if they knew the words. Members need a shared understanding of what the strategy will look like translated into practice, and their role as a team in achieving that. Clarity of purpose is only achieved when team members have the courage to work through the inevitable differences between bright and forceful team members in their judgements, opinions and preferences about the directions the organisation and their team should pursue.

The chief executive must choose the members of their senior team to fulfil its purpose (Flood et al 2001). Organisational strategies will almost always require the senior team to work closely together. So each member needs the knowledge, skills and abilities that teamwork demands. Performing well in an individual functional areas is not sufficient to justify senior team membership. Particular skills or orientations towards senior team membership include (Wageman et al 2008):

- desire to be a member of the leadership team, not just a function leader (medical director, for example)
- ability to think at a sophisticated conceptual level and take a systems approach to understanding the organisation and its relationship with its environment

- empathy to engage in robust but respectful debate without offending or alienating other team members
- integrity to build rather than undermine trust; this includes raising issues that affect the functioning of the whole organisation, even though it may compromise their own area
- commitment to keep the senior team's discussions confidential
- motivation to implement decisions agreed by the senior team.

Characteristics of successful senior teams

Several factors influence senior teams' effectiveness. For example, the higher the members' education level, the more receptive they are to creative solutions and innovation (Bantel and Jackson 1989, Hambrick et al 1996, Smith et al 1994).

Another is functional diversity. This relates to people coming from different functions or specialisms, and is associated with better corporate strategies, performance and innovation (Bantel 1993, Bantel and Jackson 1989, Hambrick et al 1996, Horwitz and Horwitz 2007, Korn et al 1992). Diversity has been shown to produce higher levels of productivity, innovation and effectiveness in senior teams.

Important conditions to ensure this diversity brings benefits without destructive dissonance or conflict are:

- Team members need to collectively and consciously value the different perspectives diversity brings, and the team leader or chief executive must model this orientation.
- The team must have a clear purpose and clear objectives to overcome the problems of fault lines (where gaps open up between subgroups in teams). This risk is particularly high where subgroups combine, such as female HR directors and male medical directors (van Knippenburg, et al 2011).

Team processes

The evidence is clear on how to develop effective team processes. It involves:

- high levels of information sharing
- influence over decision-making
- face-to-face contact
- commitment to excellence
- support for innovation.

Team processes must include:

- effective conflict management
- learning
- reflexivity.

Conflict among strong individual team members can be a particular problem because of their seniority and power. This conflict can spill out across the organisation all too easily, so a focus on team relationships is vital. In a study of software company senior teams in Ireland, team members said that what their colleagues presented as task conflict (questioning of ideas) was sometimes intended (or perceived as) as a personal attack. They felt that colleagues used this tactic to question a team member's credibility or damage their reputation (Flood et al 2001).

It is true that much consensus can lead to 'group think', where harmony and adherence to the group's norms become more important than team effectiveness. (This usually happens only where there is a dominant chief executive leading the senior team.) But the benefits of cohesion are clear. High levels of trust breed more learning in the team (Edmondson 1999). This, in turn, facilitates information being transferred across the organisation and downwards, throughout its various functions (Zand 1972).

Chief executive personality

Senior team development must also focus on the chief executive and their huge influence on relationships within the team. Peterson et al (2003)

found that a chief executive's personality has a significant influence on how senior team members work together. For example, they found that chief executive conscientiousness was related to team-level concern for the probity of their decisions. Chief executive emotional stability was linked with team cohesion and intellectual flexibility. The extent to which the chief executive was agreeable was significantly associated with team cohesion, decentralisation of power and concern for probity. All these factors also influenced organisational outcomes.

In contrast, paranoid, neurotic and narcissistic leaders create suspicion, pessimism and anxiety in the senior team. This filters down, creating a similar emotional climate in the wider organisation. Kets De Vries (1984) explores how dysfunctional leaders stoke senior team anxiety and base decision-making on irrational and unconscious processes rather than rational considerations. In another study (Farrell et al 2005), many senior managers cited the chief executive's ego as one of their biggest challenges.

How is it done?

A common approach to executive team development is to engage an external coach.

See www.astonod.com/training/team-coach-accreditation/

The coach begins by taking time to understand the team's work, using a comprehensive and rigorous instrument such as the Aston Team Performance Inventory (www.astonod.com) to measure senior team performance and observe team meetings. They then feed back, help the team set goals and offer insights into the way the team functions.

This type of coaching requires:

- knowledge of strategy development
- understanding of the complexity of senior team work
- ability to use systems thinking
- humility
- strong observational skills
- courage to confront dysfunctional behaviours.

Senior team development must focus on ensuring effective structures, processes and relationships.

Team structure

A key aspect of effective executive team development involves ensuring that the team structure is clear – particularly its purpose and objectives.

This requires a strategy to enable the organisation to succeed, effectively managing stakeholders' competing demands and clearly defining success and effectiveness.

The team must make sure this strategy is implemented and target the organisation's resources towards ensuring effectiveness and success.

Tip: Senior teams can address these issues as part of their regular (at least quarterly) development sessions.

The senior management team's objectives derive from the organisation's objectives. But they are not exactly the same. The organisation's objectives are the whole organisation's responsibility. On the other hand, the senior management team's objectives are designed to add value to the organisation's activities, in ways that enable the organisation (or wider health and care system) to achieve its objectives.

Tip: This too can be checked during development sessions.

What tasks work best?

Development must get the executive team to concentrate on the right areas. Wageman et al (2008), in their study of 120 senior management teams around the world, asked consultants to rate the teams' success in:

- meeting their stakeholders' needs
- developing their ability to sustain effective teamworking in the future
- members learning and growing as a result of their senior team membership.

They found that the best teams had 'genuinely meaningful tasks' and clear norms of conduct that enabled them to succeed. Typically they had no more than eight members.

The best senior teams carried out complex, conceptually challenging tasks that required them to work together, and made a real difference to the organisation's success. This included acquisitions, succession planning, moves to new geographical locations and moving corporate headquarters.

The less successful teams engaged with many trivial, simple, inappropriate and undemanding tasks. Their agendas were packed with items that did not really affect organisational success, and they had little time to focus on the big issues. This provides clear guidance on where to focus development.

Senior team size

The larger a senior team gets, the more difficult effective participation becomes. In teams larger than eight or nine, team conversations mutate into broadcasts. In meetings, members make speeches rather than conversing with their colleagues. And the larger the team, the more likely non-productive conflicts become. Addressing these issues is key.

If the team is to function effectively, it must be clear who is, and who is not, on the team. Wageman et al (2008) found that only 11 of the 120 teams involved agreed about who was on the team. Where the senior team's membership is unclear, the effectiveness of its work will be undermined.

Team processes

Successful teams have clear, agreed norms of conduct. These are the ground rules of how members will behave, and provide important and overt pointers to the expectations of senior team members' role performance. Wageman et al (2008) describe four key senior management team norms that should always be addressed as part of executive team development:

- commitment – treat the team member's role as seriously as your individual leadership role
- transparency – if it affects more than one of us, put it on the team table
- participation – each member's voice is welcomed on issues affecting the organisation
- integrity – what you say and what you do when you are with the team is what you say and do when you are outside the team.

Team meetings

Effective executive team meetings are vital, given the expertise present and how important their purpose is. This issue almost certainly needs to be addressed during executive team development sessions.

A good starting point is defining the agenda. One solution is to have the senior team objectives (there should be no more than six to eight) as the core items on the senior team agenda. Agendas should be short, with as few items as possible. Items that have always appeared in the past should not be on the agenda without a good reason – every agenda item must be there by virtue of its importance.

> **Tip:** Roche in Canada allows items on the senior team agenda only if they are strategic and mission-critical, and if it is only the senior team that can address them.

Agendas lead to actions. So team members must understand what they are required to achieve by the time an item has been dealt with: make a decision, identify actions, share information that will influence their subsequent actions. Executive team members

must agree on how the outcomes of their decisions can be monitored and measured to ensure they have the required impact.

From their study of 120 senior management teams, Wageman et al (2008) give this additional guidance:

- Start with the most important issues.
- Face the future, not the past – senior teams must steer the organisation forward, not spend all their time reviewing past performance.
- Prepare and participate – team members must prepare for meetings effectively in advance.
- Challenge questionable tasks (even if the chief executive put the item on the agenda).
- Delegate – many tasks dealt with by senior management teams should be delegated to empowered individuals and teams.
- Keep the large tasks large. Separating the large tasks into small pieces can feel like progress, but it stops the team working as a team in dealing with a big-picture issue.

Reflexivity

As part of their development, effective senior teams must be encouraged to take the time at the end of meetings to consider what went well, what did not go well, what could be improved and how time was used in the meeting. This form of reflexivity in action can be applied to specific projects, crisis or difficulty management, and other situations where an 'after-action review' might provide valuable learning.

> **Tip:** Teams that undertake after-action reviews are on average 25% more effective
>
> (Tannembaum and Cerasoli 2013).

A central theme in our understanding of teamworking is the importance of reflexivity. This requires teams to take time out to review their objectives, processes and performance, and how to improve them. Senior management teams should have full away-days at least every three months as part of their development. The complexities of NHS organisations and their environments require more frequent reflection and timeouts, to ensure wisdom, prudence and innovation characterise how the senior team works. In a wide variety of settings and sectors, this type of reflexivity is associated with increased productivity and innovation (Widmer et al 2009, West and Anderson 1996).

Ongoing education

Development should focus on senior team members' ongoing education. That includes training them in outstanding leadership skills, teamworking skills and strategy development. It makes sense to provide senior team members with education and training that is stretching and high quality, given their level of responsibility.

Chief executive role

Developmental interventions must also focus on the chief executive's role in team processes. The chief executive has to coach the team to focus on the big issues – the mission-critical activities – and to avoid becoming mired in operational, tactical and trivial pursuits. So coaching the team to work as a team is central to the chief executive role.

Many chief executives do good work coaching their individual team members but neglect the higher order, and more powerful, role of coaching the team to work as a team. This can be addressed during development sessions. It involves ensuring that team members are collectively taking responsibility for key challenges, such as working across system boundaries, changing culture, or encouraging QI and innovation throughout the organisation.

So developmental interventions need to focus on the competencies chief executives need and the strategies they must employ to lead the senior team effectively.

More detail is available here.

Addressing conflict

Senior teams are generally composed of forceful, bright and experienced individuals. In this cohort, discussions can easily spill over into high levels of conflict about decisions or, worse, lead to entrenched interpersonal conflict.

The evidence is unequivocal: high levels of interpersonal conflict produce an ineffective senior team. Developmental interventions are essential to help team members understand how to create positive team processes. We know that senior team members' behaviour will directly create trust or mistrust. Any team member who behaves in the following ways undermines the team's ability to explore differences of opinion in a mutually respectful, empowering and engaging way:

- always disagreeing strongly with others' views
- agreeing in team meetings but disagreeing outside
- 'talking down' fellow team members in the wider organisation
- being cynical about visions or initiatives
- being aggressive or back biting
- taking a supportive position in meetings but undermining in practice
- setting their part of the organisation against other parts (subtly or openly)
- seeking to ingratiate themselves with the chief executive by undermining their colleagues' reputations.

Many examples of dysfunctional senior management teams (Flood et al 2001, Wageman et al 2008) show how some team members lack skills to function effectively.

In one study, researchers observed senior team meetings. In those with at least five positive interactions to every negative interaction, the organisation's subsequent financial performance was much better. The best-functioning teams had a healthy balance of team member interactions, with at least as many interventions in team meetings being information-seeking or questioning rather than advocacy or pressing opinions.

Ethics

Finally, the senior team must embody the organisation's values and fundamental ethical values too. Senior team visions, strategies, missions and objectives must all be underpinned by values. Given the power the senior team wields, it is important that it embodies the values all human societies hold dear and ensures the organisation contributes to developing those values in society rather than undermining them.

References

Albrecht S, Travaglione A (2003) Trust in public-sector senior management.14 (1): 76–92

Bantel KA (1993) Top team, environment, and performance effects on strategic planning formality. 18 (4): 436–458

Bantel KA, Jackson SE (1989) Top management and innovations in banking: does the composition of the top team make a difference? 10 (S1): 107–124

Drath WH, McCauley CD, Palus CJ, Van Velsor E, O'Connor PM, McGuire JB (2008) Direction, alignment, commitment: toward a more integrative ontology of leadership. 19 (6) 635–653

Edmondson A (1999) Psychological safety and learning behavior in work teams. 44 (2): 350–383

Farrell JB, Flood PC, MacCurtain S, Hannigan AILISH (2005) CEO leadership, top team trust and the combination and exchange of information.26 (1): 22–40

Flood P, McCurtain S, West M (2001) Effective top management teams. Blackhall Publishing, Dublin

Hambrick DC, Cho TS, Chen MJ (1996) The influence of top management team heterogeneity on firms' competitive moves. 659–684

Horwitz SK, Horwitz IB (2007) The effects of team diversity on team outcomes: a meta-analytic review of team demography.33 (6): 987–1015

Kets de Vries MF, Miller D (1984) Neurotic style and organizational pathology. 5 (1): 35–55

Korn H, Milliken F, Lant TK (1992) Top management team change and organizational performance: the influence of succession, composition, and context In The annual meeting of the Academy of Management, Las Vegas, NV

Locke EA, Latham GP (eds) (2013) New developments in goal setting and task performance. Routledge, Abingdon

MacCurtain S, Flood PC, Ramamoorthy N, West MA, Dawson JF (2010) The top management team, reflexivity, knowledge sharing and new product performance: a study of the Irish software industry. 19 (3): 219–232

Peterson RS, Smith B, Martorana PV, Owens PD (2003) The impact of CEO personality on TMT dynamics: one mechanism by which leadership affects organizational performance. 88: 795–808

Smith KG, Smith KA, Olian JD, Sims Jr HP, O'Bannon DP, Scully JA (1994) Top management team demography and process: the role of social integration and communication. 39: 412–438

Tannenbaum SI, Cerasoli CP (2013) Do team and individual debriefs enhance performance? A meta-analysis. 55 (1): 231–245

Van Knippenberg D, Dawson JF, West MA, Homans AC (2011) Diversity faultlines, shared objectives, and top management team performance. 64 (3): 307–336

Wageman R, Nunes DA, Burruss JA, Hackman JR (2008) Senior leadership teams: what it takes to make them great. Harvard Business Review Press, Boston MA

West MA, Anderson NR (1996) Innovation in top management teams.81 (6): 680

Widmer PS, Schippers MC, West MA (2009) Recent developments in reflexivity research: a review. 2 (2): 2–11

Zand DE (1972) Trust and managerial problem solving. 17: 229–239

Further reading

National Leadership Council (2010). A review of guidance and research evidence. National Leadership Council, London. Available at: www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2010-LiteratureReview.pdf (accessed 13 August 2017)

NHS Leadership Academy (2013). The Healthy NHS Healthy Board guide 2013. Principles for good governance. NHS Leadership Academy, Leeds. Available at: www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf (accessed 13 August 2017)

Steward K (2014) Exploring CQC's well-lead domain: how can boards ensure a positive organisational culture? The King's Fund, London. Available at: www.kingsfund.org.uk/publications/exploring-cqcs-well-led-domain (accessed 13 August 2017)

Goldberg D (2016) Goldberg IV: the challenge for the NHS. Good Governance Institute, London. Available at: www.good-governance.org.uk/services/goldberg-iv-the-challenge-for-the-nhs/ (accessed 13 August 2017)

NHS England (2014) The NHS five year forward view, NHS England, London. Available at: www.england.nhs.uk/publication/nhs-five-year-forward-view/ (accessed 13 August 2017)

Scottish Government. 2020 Vision. Web document. Available at: www.gov.scot/Topics/Health/Policy/2020-Vision (accessed 13 August 2017)

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS Trust and NHS foundation trusts:https://improvement.nhs.uk/resources/well-led-framework/

NHS Leadership Academy (2013) NHS Healthcare Leadership Model. NHS Leadership Academy, Leeds. Available at: www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model/ (accessed 13 August 2017)

Find out more

NHS Leadership Academy
www.leadershipacademy.nhs.uk

NHS Scotland
www.gov.scot/Topics/Health/NHS-Workforce/NHS-Boards/BoardDevelopment

Health Education England
www.hee.nhs.uk

Chief executive competencies

This summary describes the competencies the chief executive needs, and the strategies they must pursue to lead the senior team effectively:

- Understanding organisations – To enable effective decision-making within the senior team, the chief executive must have a good understanding of what organisations are all about, including models of organisational structure, strategy, culture, finances, marketing, operations and business models.
- Conceptual skills – The chief executive needs an eye for detail (for example, variations between departments over time in patient satisfaction) and the ability to see the big picture (the changes in demographics and national regulation and how these will affect the organisation).
- Ability to decide – The chief executive must have the courage to make decisions when they need to be made, particularly in crises, but also the courage sometimes not to make a decision. The chief executive needs to know which waves to surf and which to let pass by.
- Ability to listen and consult – The ability to listen, rather than tell, is a key behavioural skill that chief executives have to learn to enable the senior team.
- Giving autonomy and trust – If the chief executive has selected outstanding people to be team members (their responsibility), they need to be trusted and given the autonomy to do their jobs. Excessively controlling and interfering chief executives undermine the team's ability and confidence to work together.
- Emotional intelligence – Given the potential tensions and the demands on the senior team, emotional intelligence is an especially important quality for a chief executive. The myth of the dominant, aggressive (usually male) chief executive who takes companies to success is based on an outmoded understanding of team and organisational functioning.
- Humility – Recognising realistically one's strengths, weaknesses and inadequacies is vital. Senior teams led by arrogant, narcissistic or closed leaders are doomed to failure. Chief executives must practise being open, curious (eager to learn), real (genuine and sincere in their behaviour), compassionate and appreciative in working with their senior team and the whole organisation.
- Ability to inspire – The chief executive must be able to inspire the senior team to pursue a vision, and to model the courage to discover, articulate and then embody that vision.

Integrating virtues and values into top teamwork

In recent years we have seen organisations fail on a massive scale because of a failure of values among their senior teams. Examples include:

- dishonesty with the public
- leaders more concerned with individual success than integrity
- failure of senior team self-regulation (the excesses and greed of banks)
- the damage done to our environment by senior teams in organisations failing to take responsibility for dealing with climate change
- the priority of organisational profit over contribution to the community.

Integrating values with senior team development is essential (Woods and West 2010). Peterson and Seligman (2004), two US psychologists, researched the fundamental human values in communities cross-culturally, surveying more than a million people, and identified six core areas:

- wisdom
- courage
- justice
- humanity
- prudence
- wonder.

We describe these below. Considering core human values is as vital to the effective functioning of senior teams as to any human community – given their influence, perhaps more so.

Wisdom and knowledge – the acquisition and use of knowledge by senior teams

- Creativity (originality, ingenuity) – thinking of novel and productive ways to conceptualise and do things within the organisation
- Curiosity (interest, novelty seeking, openness to experience) – taking an interest in ongoing experience for its own sake, finding subjects and topics fascinating, exploring and discovering
- Judgment and open-mindedness (critical thinking) – thinking things through and examining them from all sides, not jumping to conclusions, being able to change position in light of evidence, weighing all evidence fairly
- Love of learning – mastering new skills, topics and bodies of knowledge within the team
- Perspective (wisdom) – valuing wise counsel, having ways of looking at the world that make sense (for example, focusing on climate change issues and corporate social responsibility)

Courage – emotional strengths that involve the exercise of will to accomplish goals in the face of opposition, external or internal

- Bravery (valour) – not shrinking from threat, challenge, difficulty, or pain; speaking up for what is right even if there is opposition; acting on convictions even if unpopular within the senior team
- Perseverance (persistence, industriousness) – finishing what the senior team starts, persisting in a course of action despite obstacles
- Honesty (authenticity, integrity) – speaking the truth, but more broadly leaders presenting themselves and the organisation in a genuine way and acting in a sincere way
- Zest (vitality, enthusiasm, vigour, energy) – a senior team characterised by excitement and energy, not doing things halfway or half-heartedly, teamwork as an adventure, a senior team that is alive and activated

Humanity – an organisational strength that involves supporting and enabling all

- Caring – valuing close relations within the team and organisation, in particular those in which sharing and support are reciprocated
- Kindness (generosity, nurturance, care, compassion) – doing favours and good deeds for others in the senior team and the wider organisation, helping
- Social intelligence (emotional intelligence, personal intelligence) – being aware of the motives and feelings of those in the team

Justice – civic strengths that underlie healthy community life

- Teamwork (citizenship, social responsibility, loyalty) – working well as groups and teams, loyalty to the senior team
- Fairness – treating all people the same according to notions of fairness and justice, personal feelings not biasing decisions within the senior team or organisation, everyone being given a fair chance
- Leadership – encouraging high performance and at the same time good relations within the senior team and wider organisation

Prudence – strengths that protect against excess

- Forgiveness – forgiving those who have offended in the team somehow, accepting others' shortcomings, giving people a second chance, not being vengeful
- Modesty and humility – letting accomplishments speak for themselves
- Prudence – being careful about senior team and organisational choices, not taking undue risks, not doing things that might later be regretted
- Organisational regulation (control) – regulating the senior team and organisation, being disciplined, controlling organisational appetites and emotions

Wonder and gratitude – strengths that forge connections to the larger universe and provide meaning

- Appreciation of beauty and excellence (awe, wonder, elevation) – noticing and appreciating beauty, excellence, and/or skilled performance in various domains of life, from nature to art to mathematics to science to everyday experience
- Gratitude – being aware of and thankful for the good things that happen within the team and organisation, taking time to express thanks
- Hope (optimism, future-mindedness, future orientation) – expecting the best in the future and working to achieve it, communicating that a good future is something that can be brought about
- Humour (playfulness) – laughter and fun within the senior team and organisation, bringing smiles to the faces of people within the team, seeing the light side, senior team jokes
- Spirituality (faith, purpose) – having coherent beliefs about the higher purpose and meaning of the universe and the organisation's contribution to this, knowing where the organisation fits within the larger scheme, having beliefs about the meaning of life that shape the activities of the senior team and the organisation

Adapted extract from Woods and West (2014)

Team leadership training

In healthcare, team leadership can often be improved. Leading a team requires a particular set of skills. Tailored training for team leaders can address the gaps and give organisations the best chance of delivering high quality care.

What is this?

In organisations where work is structured around teams, it is important that leaders understand and put into practice the principle of leading in teams and team-based organisations. Team leadership training focuses on making sure leaders have the knowledge, skills and abilities to develop and structure teams, to facilitate and maintain healthy team processes and to develop positive team climates and relationships.

It is equally important to understand how to develop and maintain co-operative, supportive and effective inter-team working processes. Team leadership training focuses on providing leaders with the knowledge, skills and abilities they need to be effective team leaders in team-based organisations.

Why is this important?

Team leaders influence co-ordination, creativity, knowledge-sharing, problem management, actions, affective tone (for example, whether there is a positive or negative climate), efficacy, empowerment, potency and commitment to the team and the organisation (Burke et al 2006). However, in healthcare organisations there are some key tripwires that can jeopardise team performance and, in turn, service delivery.

Hackman (2002) identified five tripwires that can cause team leaders to fail:

- Calling the performing unit a team, but really managing members as individuals: One approach to leading teams involves assigning individual responsibilities within a team and co-ordinating individual activities. Another is to assign a team task and give team members responsibility for determining how the task should be completed. Some use a mixed model, where they tell people they are a team but treat them as individuals, with individual performance appraisal and individual rewards. This confuses team members and leads to team ineffectiveness.
- Falling off the authority balance beam: Leadership involves exercising authority in some areas and not in others – or, conversely, giving autonomy in some areas but withholding it in others. Team leaders need to make sure there is clear direction for the team's work while at the same time giving them the authority, within boundaries, to determine the means by which they achieve their ends. A typical mistake is giving a team too much autonomy early in its life, when direction is needed, and then intervening heavily later.

- Simply assembling a large group: Hackman shows that three important elements of structure are necessary:
  - a well-designed team task that represents a meaningful and motivating piece of work, accompanied by sufficient autonomy for team members to be able to conduct the work successfully and get direct feedback about the results of their efforts
  - a well-assembled team, as small as possible while having the appropriate mix of skills and resources to enable the members to get the job done efficiently
  - clear, explicit and unambiguous information for the team about its authority and accountability.
- Specifying challenging team objectives but skimping on organisational support: Teams in NHS organisations are often required to achieve ever-more challenging targets. If leaders do not ensure adequate organisational resources, teams will be unlikely to work effectively. These include:
  - information that enables the team to achieve their objectives
  - resources, such as sufficient staff, budget, appropriate work space.
- Assuming that members already have all the competencies they need to work well as a team: Effective team leaders coach and help individual team members, and the team as a whole, through periods of difficulty as well as through periods of success. They do not make the mistake of assuming that team members are competent to deal with new challenges as they come up. Team leadership involves constant awareness of team processes and active intervention when necessary.

To make sure team leaders avoid these tripwires, training in team leadership is vital.

What is the evidence?

Over the past 10 years, research has consistently demonstrated the importance of leadership in determining the effectiveness of healthcare teams. But at the same time, leadership is often poor (Borrill et al 2000, Øvretveit et al 2002, Plsek and Wilson 2001).

West et al (2003) analysed leadership in a sample of 3,447 respondents from 98 primary health care teams, 113 community mental health teams and 72 breast cancer care teams in the NHS. They found that leadership clarity and low conflict over leadership was associated with better team processes – and these, in turn, affected team outcomes.

Team leadership in health services is closely linked to organisational performance too. In a study involving 17,990 employees from 86 hospitals, Shipton et al (2008) examined the relationship between leadership effectiveness (mostly among team leaders) and hospital performance, taking into account external quality measures and the number of patient complaints. The results revealed that leadership style was associated with quality of care, clinical governance and patient complaints.

Increasingly, research evidence suggests that effective healthcare teams have shared, rather than directive, leadership (Aime et al 2014, Carson et al 2007, West et al 2014). There may well be a designated leader, but leadership itself is shared. Leadership shifts between team members as expertise requirements and motivational orientations vary with the task at hand.

The evidence also shows that leaders should not exhibit favouritism in teams (Graen and Uhl-Bien 1995). The greater the personal compatibility with particular followers, the more time team leaders spend with them and the more likely they are to attribute follower success to ability. Conversely, the

lower the compatibility, the less time they spend with particular followers and the more likely they are to attribute success to situational factors.

As transformational leadership theory suggests, team leaders who offer a high degree of individual consideration and support for each of their followers ensure more effective team work, co-operation and quality of care (Howell and Avolio 1993, Gilmartin and D'Aunno 2007).

When working with team members, formal leaders can play a key role in modelling compassion (West and Chowla 2017). This involves team leaders:

- paying careful attention to each of their team members and their needs and challenges at work
- responding empathically in each case
- taking intelligent action to help and support them.

Team leaders need to be trained to ensure that teams take time out on a regular basis, to review what they are trying to achieve and how they are going about it. Those who do this lead teams that are much more effective and much more innovative in delivering patient care (Widmer et al 2009, Schippers et al 2014, 2015).

How is it done?

Overall, for effective team-working, leaders need to create a positive emotional environment. Training leaders to model compassion will help them create a climate within which team members listen to each other, understand their shared challenges, empathise and help each other. This has a significant influence on team performance (West and Chowla 2017). (See Developing compassionate leadership.)

There are three core elements to the team leader training: leading, managing and coaching. These are described over the next few pages.

Leading

Team leaders need training to ensure that the team has a clear task to perform (and one that is best done by a team), underpinned by no more than six-to-eight clear, agreed, challenging objectives. They must also understand the need to make sure the team has the resources it needs to do its work, and that team members are clear about who is in the team (the team boundaries).

The size of the team is important too. Teams should include the minimum number of people needed to perform the task effectively, while not being large. When there are more than six-to-eight members in a team, team working becomes progressively more challenging.

Managing the team

Training involves learning to manage the team to ensure agreement about clear, shared and challenging team objectives aligned to the organisational mission and vision. The team leader must also ensure the role of each team member is clear to everyone. Team leaders must learn how to evaluate team performance in relation to:

- team outcomes
- team viability (the team's sustained ability to work well together)
- team member growth and wellbeing
- team innovation and inter-team relations (co-operation with other teams and departments within the organisation).

Training also involves learning to review with the team, its team processes, strategies and objectives. It is usually the responsibility of the team leader to set up 'time out' from the team's daily work to enable these review processes to take place. Some may doubt the wisdom of taking time out from a team's busy work to conduct these reviews, but there is strong evidence that teams that do this are far more productive and effective than those that do not (Tannenbaum and Cerasoli 2013, Schippers et al 2015).

Coaching the team

Training must also focus on team coaching – the facilitation and management of day-to-day team processes (Hackman and Wageman 2005). Hackman and Wageman (2005) describe three core ways in which leaders can coach their teams:

- motivating team members by increasing commitment and a sense of identity
- encouraging effective task performance strategies by minimising unimportant work and ensuring effective co-ordination and task focus
- ensuring members' knowledge and skills are used and developed effectively.

Team leaders must be trained in coaching skills (see Coaching) so they can coach and support the team to success. The team leader has to learn to:

- coach the team as a whole, responding to how well members are interacting and communicating with each other
- intervene to encourage more meetings and information exchange between particular members
- help shape a supportive approach to suggestions from team members
- develop team processes that help the team to perform effectively, by nurturing good decision-making, problem-solving, conflict management and the development of new and improved ways of working together.

Team leaders must also be trained in how to manage team conflicts and relationship problems. This includes encouraging good humour, positive feedback, confidence and enthusiasm through socialising new team members, through messages about the wider organisation and through modelling relationships with other teams and departments across the organisation. Encouraging celebrations of success and appreciation of contributions is vital.

The leader needs to be trained to facilitate every member of the team to take responsibility for managing, coaching and leading. If team members take responsibility for direction, support, influencing and authority in the team, the team itself is likely to be highly effective (Zaccaro et al 2009).

The research evidence suggests that shared leadership is positively related to team performance (Carson et al 2007, Mathieu et al 2008).

Tips

- Training must emphasise that the most important skill of team leadership is listening to team members, along with understanding, empathising and helping.
- Team leaders must understand how significant their role is in creating climates of positive, cohesive and effective climates.
- Encourage team leaders to always and overtly value diversity of people and views in the team.
- Encourage team leaders to model and build good inter-team relationships and collaboration as a core part of their leadership roles.
- Team leaders must understand their role in making sure the team regularly takes time out to review their objectives, processes and functioning, to achieve high quality and ensure continuous improvement.

For extensive resources on healthcare team leader training, go to: www.astonod.com

References

Aime F, Humphrey S, DeRue DS, Paul JB (2014) The riddle of heterarchy: power transitions in cross-functional teams. 57 (2): 327–352

Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D West MA (2000) The effectiveness of health care teams in the National Health Service. University of Aston in Birmingham, Birmingham

Burke CS, Stagl KC, Klein C, Goodwin GF, Salas E, Halpin SM (2006) What types of leadership behaviors are functional in teams? A meta-analysis. 17: 288–307

Carson JB, Tesluk PE, Marrone JA (2007) Shared leadership in teams: an investigation of antecedent conditions and performance. 50 (5): 1217–1234

Gilmartin MJ, D'Aunno TA (2007). Leadership research in healthcare: a review and roadmap. 1 (1): 387–438

Graen GB, Uhl-Bien M (1995) Relationship-based approach to leadership: development of leader-member exchange (LMX) theory of leadership over 25 years: applying a multi-level multi-domain perspective. 6 (2): 219–247

Hackman JR (2002). Leading teams: setting the stage for great performances. Harvard Business Press, Harvard MA

Hackman JR, Wageman R (2005). A theory of team coaching. 30 (2): 269–287

Howell JM, Avolio BJ (1993) Transformational leadership, transactional leadership, locus of control, and support for innovation: key predictors of consolidated-business-unit performance. 78 (6): 891–902

Mathieu J, Maynard MT, Rapp T, Gilson L (2008) Team effectiveness 1997–2007: a review of recent advancements and a glimpse into the future. 34 (3): 410–476

Øvretveit J, Bate P, Cleary P, Cretin S, Gustafson D, McInnes K, McLeod H, Molfenter T, Plsek P, Robert G, Shortell S, Wilson T (2002) Quality collaboratives: lessons from research. 11 (4): 345–351

Plsek PE, Wilson T (2001) Complexity science: complexity, leadership, and management in healthcare organisations. 323 (7315): 746–749

Schippers MC, Edmondson AC, West MA (2014) Team reflexivity as an antidote to team information-processing failures. 45 (6): 731–769

Schippers MC, West MA, Dawson JF (2015) Team reflexivity and innovation: the moderating role of team context. 41 (3): 769–788

Shipton H, Armstrong C, West M, Dawson J (2008) The impact of leadership and quality climate on hospital performance. 20 (6): 439–445

Tannenbaum SI, Cerasoli CP (2013) Do team and individual debriefs enhance performance? A meta-analysis. 55 (1): 231–245

West MA, Borrill CS, Dawson JF, Brodbeck F, Shapiro DA, Haward B (2003) Leadership clarity and team innovation in health care. T14 (4): 393–410

West MA, Chowla R (2017) Compassionate leadership for compassionate health care. In Gilbert P (ed). Compassion: concepts, research and applications. Routledge, London: 237–257

West M, Lyubovnikova J, Eckert R, Denis JL (2014) Collective leadership for cultures of high quality health care. 1 (3) 240–260

Widmer PS, Schippers MC, West MA (2009) Recent developments in reflexivity research: a review. 2 (2): 2–11

Zaccaro SJ, Heinen B, Shuffler M (2009). Team leadership and team effectiveness. In Salas E, Goodwin GF, Burke CS (eds) Team effectiveness in complex organizations: cross-disciplinary perspectives and approaches. Routledge, New York: 83–111

Teamwork training

Healthcare must operate around teams. The most successful organisations acknowledge this and encourage a team-based culture, supported through training in the specific skills this approach requires.

What is this?

Teamwork training focuses on developing the knowledge, skills, abilities and values that are the basis for teamwork competencies. (For a description of these, see Selecting for team orientation.) It also focuses on ensuring good communication, co-ordination and collaboration in healthcare teams and supporting the transfer of training to the work environment.

Components may include:

- communication skills training
- cross training (where team members learn about each other's roles)
- error management training
- guided team self-correction
  See also Team reflexivity and After action reviews
- team mental model training, ensuring shared understanding of task, team roles and co-ordination strategies
- team adaptation
- co-ordination training.

Tip: In the United States, the highly structured TeamSTEPPS programme has been widely used successfully (King et al 2008, Hughes et al 2016). www.ahrq.gov/teamstepps/about-teamstepps/index.html

Why is this important?

Many interventions require healthcare professionals from different disciplinary backgrounds to come together, combining their skills and knowledge, to provide effective and timely care. Human fallibility combined with complex and often stressful tasks inevitably leads to some degree of error (Sharit 2006).

The challenge facing healthcare organisations is how to develop and sustain effective team-based working that spans professional, hierarchical and organisational boundaries (Richardson et al 2010) to reduce medical error and improve patient outcomes.

Team-based working is the optimal work design for improving health services (Bosch et al 2009, West and Markiewicz 2016, Lyubovnikova and West 2013) because teams can synthesise knowledge, skills and resources to deliver high quality, timely care to patients. Effective teamwork leads to improved patient safety and reduced medical errors in hospital settings (Baker et al 2006, Heinemann and Zeiss 2002, Manser 2009).

Studies link teamwork in primary health care with lower hospitalisation rates (Sommers et al 2000) and lower error rates in operating theatres (Sexton et al 2000). In a study of community health teams over a six-year period, Jansson et al (1992) found that quality of teamwork was related to reductions in emergency visits.

The link between teamwork and clinical outcomes has been demonstrated across a range of contexts, including intensive care units, operating rooms, nursing homes, accident and emergency departments, maternity suites and surgical wards (Salas et al 2009).

Although teamwork is vital for high quality healthcare, the quality of teamwork in the NHS is often poor. Borrill et al (2000) and Lyubovnikova et al (2015) found this leads to:

- errors that harm staff and patients alike
- injuries to staff
- poor staff wellbeing
- lower levels of patient satisfaction
- poorer quality of care
- higher patient mortality.

Nembhard and Edmonson (2006) found that medical errors were often a result of poor teamwork and status hierarchies. These hierarchies are associated with lower-status team members being reluctant to challenge the decisions of more senior team members. In an analysis of 193 critical prescribing incidents (Lewis et al, 2009), one-third were attributed to team-related problems such as:

- hierarchies
- prescribing etiquette (failure to challenge)
- ignoring hospital regulations
- neglecting best practices in the interests of team relationships.

It is quality of teamwork that counts in ensuring high quality care.

Research also shows that quality of teamwork predicts the extent to which teams develop and implement innovation in healthcare, such as introducing new and improved treatments for patients or new and improved methods of delivering care. In two samples of healthcare teams (66 and 95 teams respectively), Fay et al (2006) found that multidisciplinary teams produced higher quality innovation than less diverse teams. However, this was only the case when the teams functioned effectively.

What is the evidence?

Teamwork in healthcare is often highly dynamic, with people taking part in multiple teams and on an ad-hoc basis, compared with intact teams that work together over a sustained period of time. Reviews reveal that teamwork training is equally positives for ad-hoc and intact teams (Manser 2009).

Reviews of team training across industries suggest that participation in team training can lead to an average 20% difference in performance in both processes and performance (Salas et al 2008a). Reviews in healthcare suggest similarly positive results (Buljac-Samardzic et al 2010, Weaver et al, 2010, Rabøl et al 2012, Eppich et al 2011).

Weaver et al (2014) published a synthesis of the research, based on previous reviews of team training in healthcare and an updated review of more recent research. They found clear evidence that team training is effective in a wide variety of healthcare teams (including critical care, emergency care and surgery). They also showed that the most robust effects occur when the team training is carefully designed through:

- pre-planning
- preparatory work with team members
- interdisciplinary training
- tools to support active transfer and sustained use of teamwork practices back into daily work life.

In the largest and most rigorous review of research in healthcare to date, Hughes et al (2016) analysed data from 129 studies of the effects of teamwork training in healthcare. They concluded that healthcare team training:

- surpasses employees' expectations regarding the value and enjoyment of the process
- succeeds in transferring learning to the job
- leads to improved organisational and patient outcomes.

There are also demonstrable effects in reducing patient mortality.

The review showed that healthcare team training is effective regardless of team composition (whether interprofessional or interdisciplinary), who is involved (for example, whether students or clinicians), and the extent to which trainees are dealing with acute cases in their daily work. The results also suggest this type of training can usefully be provided at any career stage, for clinicians and students alike.

The authors conclude that teamwork training should be embedded in every healthcare course curriculum (for example, at nursing school and medical school) and in continuing education programmes for practising clinicians.

How is it done?

Team training can focus on developing teamworking skills among individuals or with whole teams. At its heart, teamwork is about how individuals interact, co-operate and engage to achieve team objectives. It is about interaction, information-sharing and influencing decision-making. It depends on factors such as:

- shared understanding of tasks
- clarity about roles effective listening, questioning and disagreement
- trust.

Team interactions are crucial to effective team performance and must form the basis of team training, whether the focus is on individuals or whole teams.

For example, high levels of conflict in teams are damaging and interpersonal conflict is particularly damaging (De Dreu and Weingart 2003, De Wit et al 2012, Tjosvold 1998). Aggressive, intimidating and otherwise confrontational behaviours undermine effective team functioning. This is a crucial area of team training whether the intervention is delivered to individuals or to whole teams.

Similarly, if teams are to model compassionate care for patients, team members must be trained in how to interact compassionately with fellow team members (regardless of status, demography or disciplinary background). This is especially important given the level of stress experienced by healthcare staff. Team members need training in how to pay attention to each other as well as how to understand, empathise and help each other (see Compassionate behaviour training).

Team training can be divided into a number of types, each requiring a different approach (West 2012). Teams and organisations should be clear about the type of team training required:

Team start-up training

This type of training is suitable for a team beginning its work that needs to clarify its objectives, strategies, processes and roles. Start-up training can help shape the team climate, determine clarity of direction, and shape teamwork practices. It includes:

- ensuring the team has a whole and meaningful task to perform
- clarifying team objectives
- setting out ways to evaluate team members' activities
- setting up processes for regular member feedback
- making sure team performance as a whole is monitored
- establishing system for regular communication and review.

Regular formal reviews

Formal reviews usually take the form of awaydays (usually one-to-two days long) during which a team reviews its objectives, roles, strategies and processes, to maintain and promote effective functioning. As in any other area of human activity, regular review of functioning can lead to greater awareness of strengths, skills, weaknesses and problem areas, and improve future functioning. (For more detail, see Team reflexivity and after-action reviews).

Addressing known task-related problems

To deal with specific task-related problems, the team needs to take time out to define the issue, then develop alternative options for overcoming the problem, choose a way forward, and implement the intervention.

Formal reviews of team functioning

This can be done by using a questionnaire to measure team functioning such as the Aston Team Performance Inventory (ATPI) or the Team Climate Inventory (TCI). These questionnaires, which have been used by hundreds of healthcare teams, are well validated and have excellent reliability. They can be used as diagnostic instruments to identify problems in team functioning and help identify techniques associated with particular team problems. Team members then come together to review results, ideally with a coach or facilitator to address issues.

To find out more, go to www.astonod.com or Anderson and West (1998).

Crew resource management training

This approach was introduced as a team development strategy in the 1970s following several serious crashes in the US aviation industry. The aim was to help cockpit crews use resources effectively, including people, information and equipment. Since then, it has been extended to a variety of healthcare settings.

The training involves presenting trainees with important information about the task at hand, including illustrations of effective and ineffective performance, opportunities for practice and helpful and timely feedback after-practice (Salas et al 2006).

Crew resource management training should focus on the following abilities:

- communication: sending and receiving accurate information and feedback
- briefing, analysis and planning: planning actions and strategies, and ensuring tasks are completed effectively
- backing up: anticipating each other's support needs and shifting resources and workloads to ensure effectiveness
- mutual performance monitoring: monitoring each other's performance, intervening as appropriate and giving feedback
- team leadership: setting direction, managing team processes and coaching the team
- decision-making: making sound judgements on the basis of whatever information is available
- task-related assertiveness: influencing team task decisions through appropriate interventions
- team adaptability: adapting to changing circumstances and demands
- shared situation awareness: using information to develop a common understanding of the environment in which the team operates.

Social process training

Another form of team training is social process interventions. These focus on interpersonal relationships, social support, team climate, support for growth and development of team members, and conflict resolution. They aim to promote a positive social climate and team member wellbeing.

This approach should be used where a team has unsatisfactory answers to one or more of these questions:

- Does the team provide adequate levels of social support for its members?
- Does the team have constructive, healthy approaches to conflict resolution?
- Does the team have a generally warm, compassionate and positive social climate?
- Does the team provide adequate support for skill development, training and personal development of all its members?

Tips

Identify critical teamwork competencies as a focus for training content: It is important to define precise learning outcomes and content, to capture team competencies. Teamwork focuses on leadership, mutual performance monitoring, backup behaviour, adaptability and team orientation. Other training strategies include cross-training, where competencies include knowledge of the roles and responsibilities of other team members.

Emphasise teamwork over task work to improve team processes: Teamwork and task work are both components of team performance. But the most effective team training programmes focus on teamwork (skills such as communication, co-ordination and collaboration).

Tailor training to the desired outcomes. Effective team training does not come in a standard off-the-shelf box – it uses sound instructional principles, planning, follow-up and an environment conducive to transferring the new abilities to the job environment. Most training begins with a plain English classroom-based lecture, discussion or video-based session and then allows time for either simulation or role play of new skills.

Use simulation-based training to ensure relevance to the job. Simulation-based training offers opportunities for trainees to implement and practise new skills in environments similar to their daily job (for example, using a mannequin in a resuscitation scenario.) To use simulation effectively, you need to create realistic scenarios for trainees.

Provide descriptive, timely and relevant feedback. Feedback can be either outcome based (for example, did the simulated patient survive?) or behaviour based (did the trainees communicate, co-ordinate and cooperate well?) Feedback is usually in the form of a debrief, during which trainees discuss their performance with the help of a facilitator.

Evaluate reaction data, clinical outcomes, learning and behaviour on the job. Training must be evaluated to measure learning outcomes and determine programme effectiveness. Several frameworks have been developed for training evaluation (see Kraiger et al 1993) and include:

- reactions (did trainees like the training and find it useful?)
- knowledge/learning (did trainees increase their understanding of the competencies targeted by training?)
- behaviour (did trainees change their behaviour on the job or in relevant simulations?)
- results (were important outcomes affected?).

Reinforce desired teamwork behaviours through coaching and performance evaluation The behaviours targeted during training must be reinforced on the job so teamwork behaviours need to be incorporated into coaching and mentoring sessions as well as performance evaluation.

Tips adapted from Salas et al 2008b.

References

Anderson N, West, M (1998) Measuring climate for work group innovation: Development and validation of the team climate inventory. *Journal of Organizational Behaviour* 19: 235–258

Baker DP, Day R, Salas E (2006) Teamwork as an essential component of high-reliability organizations. *Health Services Research* 41 (4, pt 2): 1576–98

Borrill C, West M, Shapiro D, Rees A (2000) Team working and effectiveness in health care. *British Journal of Healthcare Management* 6 (8): 364–371

Bosch M, Faber MJ, Cruijsberg J, Voerman GE, Leatherman S, Grol RP, Hulscher M, Wensing M (2009) Review article: effectiveness of patient care teams and the role of clinical expertise and coordination: a literature review. *Medical Care Research and Review* 66 (6): 5S–35S

Buljac-Samardzic M, Dekker-van Doorn CM, van Wijngaarden JD, van Wijk KP (2010) Interventions to improve team effectiveness: a systematic review. *Health Policy* 94 (3): 183–195

Department of Health (2010) The NHS Constitution. The NHS belongs to us all. Department of Health, London. Available at: www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx (accessed 13 August 2017)

Eppich W, Howard V, Vozenilek J, Curran I (2011) Simulation-based team training in healthcare. *Simulation in Healthcare* 6 (Suppl): S14–S19

Fay D, Borrill C, Amir Z, Haward R, West MA (2006) Getting the most out of multidisciplinary teams: a multi-sample study of team innovation in health care *Journal of Occupational and Organizational Psychology* 79 (4): 553–567

Guzzo RA (1996) Fundamental considerations about work groups. In West MA (ed) The Handbook of Work Group Psychology. John Wiley, Chichester: 3–23

Heinemann GD, Zeiss AM (2002) A model of team performance. In Heinemann GD, Zeiss AM (eds) Team performance in health care. Springer, Boston MA: 28–42

Hughes AM, Gregory ME, Joseph DL, Sonesh SC, Marlow SL, Lacerenza CN, Benishek LE, King HB, Salas E (2016) Saving lives: a meta-analysis of team training in healthcare. *Journal of Applied Psychology* 101 (9): 1266–1304

Jansson A, Isacsson Å, Lindholm LH (1992) Organization of health care teams and the population's contacts with primary care. *Scandinavian Journal of Primary health care* 10 (4): 257–265.

King HB, Battles J, Baker DP, Alonso A, Salas E, Webster J, Toomey L, Salisbury M. In Henriksen K, Battles JB, Keyes MA, (2008) TeamSTEPPS™: team strategies and tools to enhance performance and patient safety. In Henriksen K, Battles JB, Keyes MA, Grady ML (eds) Advances in patient safety: new directions and alternative approaches, vol 3: Performance and tools. Agency for Healthcare Research and Quality, Rockville, Washington DC

Kraiger K, Ford JK, Salas E (1993) Application of cognitive, skill-based, and affective theories of learning outcomes to new methods of training evaluation. *Journal of Applied Psychology* 78 (2): 311–328

Lewis PJ, Dornan T, Taylor D, Tully MP, Wass V, Ashcroft DM (2009). Prevalence, incidence and nature of prescribing errors in hospital inpatients. Drug Safety 32 (5): 379–389

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectivesness for the delivery of high quality patient care. In Salas E, Tannembaum SI, Cohen D, Latham G (eds) Developing and enhancing teamwork in organizations. Jossey Bass, San Francisco CA: 331–372

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015). 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24 (6): 929–950

Manser T (2009) Teamwork and patient safety in dynamic domains of healthcare: a review of the literature. *Acta Anaesthesiologica Scandinavica* 53 (2): 143–151

Nembhard IM, Edmondson AC (2006) Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior* 27 (7): 941–966

Rabøl LI, McPhail M, Bjørn B, Anhøj J, Mogensen T, Østergaard D, Andersen H B (2012). Outcomes of a classroom-based team training intervention for multi-professional hospital staff. *Medical Teacher* 34 (10): 868–869

Richardson J, West MA, Cuthbertson BH (2010) Team working in intensive care: current evidence and future endeavours. *Current Opinion in Critical Care* 16 (6): 643–648

Richter A, Dawson JF, West MA (2011) The effectiveness of teams in organizations: a meta-analysis. *The International Journal of Human Resource Management* 13: 1–21

Salas E, Almeida SA, Salisbury M, King H, Lazzara EH, Lyons R, Wilson KA, Almeida PA, McQuillan R (2009) What are the critical success factors for team training in health care? *Joint Commission Journal on Quality and Patient Safety* 35 (8): 398–405

Salas E, DiazGranados D, Klein C, Burke CS, Stagl KC, Goodwin GF, Halpin S M (2008a) Does team training improve team performance? A meta-analysis. *Human Factors* 50 (6): 903–933

Salas E, DiazGranados D, Weaver SJ, King H (2008b) Does team training work? Principles for health care. Academic Emergency Medicine 15 (11): 1002–1009

Salas E, Wilson KA, Burke CS, Wightman DC (2006). Does crew resource management training work? An update, an extension, and some critical needs. *Human Factors* 48: 392–412

Sexton JB, Thomas EJ, Helmreich RL (2000) Error, stress, and teamwork in medicine and aviation: cross sectional surveys. *British Medical Journal* (Clinical research edition) 320 (7237): 745–749

Sharit J (2006). Human error. In Salvendy G (ed) Handbook of human factors and ergonomics. John Wiley and Sons, Hoboken NJ

Sommers LS, Marton KI, Barbaccia JC, Randolph J (2000). Physician, nurse, and social worker collaboration in primary care for chronically ill seniors. *Archives of Internal Medicine* 160 (12): 1825–1833

Tannenbaum SI, Salas E, Cannon-Bowers JA (1996) Promoting team effectiveness. In MA West (ed) Handbook of work group psychology. Wiley, Chichester: 503–529

Weaver SJ, Dy SM, Rosen MA (2014) Team-training in healthcare: a narrative synthesis of the literature. *BMJ Quality and Safety* 23 (5): 359–372

Weaver SJ, Lyons R, DiazGranados D, Rosen MA, Salas E, Oglesby J, Augenstein JS, Birnbach DJ, Robinson D, King HB (2010). The anatomy of health care team training and the state of practice: a critical review. *Academic Medicine* 85 (11): 1746–1760

West BJ, Patera JL, Carsten MK (2009). Team level positivity: investigating psychological capacities and team level outcomes. *Journal of Organizational Behaviour* 30: 249–267

West MA, Markiewicz L (2016). Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds). The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA (2012) Effective teamwork: practical lessons from organizational research. John Wiley, Chichester

Team-based appraisal

This approach to appraisals focuses on the team's performance, with individuals appraised by fellow team members, to emphasise team-based working throughout an organisation.

What is it?

Team-based organisations regularly carry out appraisals of teams, rather than individuals. These team appraisals involve:

- reviewing the appropriateness of the team task and making sure it is aligned with the organisation's vision
- assessing team performance, based on input from those the members report to and work with (including patients and other teams in the organisation)
- setting objectives as a team, incorporating a strong commitment to developing new and improved ways of delivering services
- asking the team to describe how senior leaders and the organisation could better support their work
- reviewing the level of responsibility and autonomy to allow for and encourage decision-making, innovation and quality improvement
- asking how the team's work could be more challenging, rewarding, engaging and powerful in contributing to the organisation's overall mission.

After this process, the team carries out appraisals of individual team members. We explain this in more detail over the next few pages.

Why is it important?

There is general understanding in the NHS that good teamwork is vital for good healthcare. However, there is a lack of attention to ensuring the quality of teamworking in the NHS. Estimates (Lyubovnikova et al 2015) suggest that as many as 60% of staff work in teams:

- that do not have clear objectives
- where staff do not work closely together to achieve objectives
- where staff do not meet regularly to review their performance and how to improve it.

This poor teamworking leads to higher levels of errors, injuries to staff, stress and avoidable patient deaths – all the more reason to ensure high quality teamworking in healthcare. Team-based appraisals focus sharply on team functioning and performance.

The main causes of poor teamworking include teams not having clear tasks and objectives (Hackman and Wageman 2005, Wageman et al 2008). More than 30 years' research into teamworking in the NHS has consistently shown that clear team objectives are the most important factor determining healthcare teams' effectiveness (Lyubovnikova and West 2013, West and Lyubovnikova 2013, West and Markiewicz 2016).

The tasks that teams perform should actually require teamwork, rather than be separate task components that might be better performed by individuals working in parallel.

If a team is to function effectively, it needs the freedom and authority to make the decisions that allow it to provide high quality care or services, and to develop and implement new and improved ways of doing things. This discretion is key to effective teamwork and, in turn, to high quality and continually improving care.

Finally, team-based appraisal is important because it ensures that organisations that intend to develop, maintain and support teamworking are not – paradoxically – structured around individual performance. If teams are seen as the key to performance but the organisational systems are geared towards managing individuals, the organisation will be far less effective.

Team-based appraisals are consistent with the notion that in healthcare, most of the work is performed by teams, and most tasks require teams to complete them.

What is the evidence?

Considerable evidence shows how important the quality of teamworking is to healthcare and to healthcare organisations' performance generally. Indeed, the accumulation of evidence in the NHS over the past 30 years about the importance of teamwork to healthcare is unique worldwide.

This evidence makes the case, powerfully and clearly, that quality of teamwork affects a range of crucial factors, including (West and Markiewicz 2016, Lyubovnikova et al 2015, Lyubovnikova and West 2013, West and Lyubovnikova 2013):

- levels of errors
- injuries to staff
- stress
- patient satisfaction
- care quality
- staff absenteeism
- bullying and harassment
- turnover
- avoidable patient deaths.

International research consistently supports the research findings in the NHS (see reviews by West and Markiewicz 2016, Lyubovnikova et al 2015, Lyubovnikova and West 2013).

There is also evidence from NHS organisations that have made great strides in developing team-based working in general, and team-based appraisals in particular. Many have used the Aston team journey to develop and sustain team appraisals.

The Aston team journey

This is an approach to team-based appraisal based on seven elements: team identity, team objectives, team member roles, decision-making, communication, team reflexivity and inter-team working. Many healthcare organisations have implemented this approach and derived tangible benefits for patient outcomes, including Merseycare NHS Foundation Trust, Birmingham Children's Hospital, North Staffordshire NHS Trust and Lincolnshire Community Health Services NHS Trust.

Find out more at: www.astonod.com/team-tools/aston-team-journey/.

How is it done?

Team-based appraisals focus on:

- the extent to which the team achieved its objectives in the previous year (or relevant performance period)
- what factors enabled the team to achieve success and what obstacles prevented or hindered the team
- the appropriateness of the team's task and its alignment with the organisation's mission and vision
- objectives for the coming year or other relevant performance period (no more than five to seven clear, agreed, challenging objectives aligned to the organisation's purpose)
- the functioning of the team and team members' wellbeing
- resources and support required from team leaders, and from the wider organisation
- feedback from other teams inside or outside the organisation with which the team works
- feedback from patients or service users (or whoever the team provides services for)
- what the team leader does that enables the team to function effectively
- what the team leader does that hinders the team from functioning effectively
- what the team leader could do more to help the team function effectively
- how senior leaders and the organisation could better support the team's work
- ways in which the team could develop its role and function
- ways in which the team's work could be more challenging, rewarding, engaging and powerful in contributing to the organisation's overall mission
- opportunities for quality improvement in particular, and innovation more generally
- ways to improve effectiveness overall
- the team's greatest successes
- the team's major strengths and development needs.

Team appraisals generally should ensure that performance criteria against which teams can be measured are appropriate.

These criteria include:

- Team outcomes – The team's performance, be it recruiting staff, treating patients or providing support services; it is likely to be best defined and evaluated by the team's 'customers' (Hackman 2002, West 2012, West et al 2006).
- Team viability – The team's sustained ability to work well together. If some team members have chronic interpersonal conflicts, or members are keen to leave the team, the team's performance has not been functional (Hackman and Wageman 2005).
- Team member growth and wellbeing – Team members' learning, development and satisfaction. In well-functioning teams, members learn from each other constantly (Hackman 2002, West 2012).
- Team innovation and quality improvement – The way the team introduces new and improved ways of doing things. This is an important barometer of team functioning. Teams should be sources of creativity and innovation because they bring together individuals with diverse knowledge, orientations, skills, attitudes and experiences in a collective enterprise, creating the ideal conditions for creativity (West 2002).

- Inter-team relations – Co-operation with other teams and departments in the organisation. Teams must not only be cohesive: they must work effectively with other teams and departments to deliver goods or services. Otherwise, team cohesion may simply reinforce silos within the organisation, undermining collective efforts to achieve organisational goals (West and Markiewicz 2016).

Dealing with difficulties

Team-based appraisals can identify difficult problems that the team faces. Teams may need help and support to deal with these.

The most effective team-based organisations usually provide internal coaches (perhaps working alongside external coaches) who support teams that are having difficulty – in short, 'process assistance' or 'process support' (see www.astonod.com)

(Hackman and Wageman 2005).

Providing feedback to individuals

If team members are to grow and develop in their jobs, they need regular, constructive conversations about their individual performance, even if they are working in a team appraisal system. As less hierarchical structures lead to larger spans of control (managers have to manage more people), giving team members the direction and feedback they need is more of a problem. Within the team philosophy, this is best done by fellow team members, rather than the team leader (West and Markiewicz 2004). For this reason, team-based appraisals also include individual team member appraisals.

There are several ways of providing direction and feedback for team members:

- Option 1 – The team leader collects team members' views on predetermined performance criteria, collates the information and gives feedback to the individual.
- Option 2 – At the time of the team performance review, team members also discuss individual performance, sometimes with an outside facilitator's help.
- Option 3 – A subgroup of the team is delegated to consider individual aspects of performance and gives feedback to individuals on that area only.

Team members who have been accustomed to traditional forms of manager-led appraisal may take some time to feel comfortable with participative processes. In the early days of this approach, it may be appropriate for individuals to receive more anonymous feedback, presented in aggregated form. The team can then aspire to move towards a system where all members meet in a workshop to give feedback on performance and set goals with each other in an open, supportive and professional manner.

Use questionnaires

Using a questionnaire-based approach may be helpful. The mechanics are straightforward: team members are asked to rate each other's skills and performance, and feedback is collected (via the questionnaire) from the team leader and all team members. Answers are then analysed and feedback is given to the individual.

This could be based on the Knowledge, skills and abilities for teamwork questionnaire.

This approach improves team communication processes, extends ownership and involvement, and enhances the concept of team feedback. It can also help team members understand the perceived value of:

- their contribution to the team's output, measured against predetermined targets derived from the team's overall goals
- their performance in their team role
- their contributions in the areas of communication, goal setting, giving feedback to other team members, planning and co-ordination, collaborative problem solving, conflict resolution, innovation, and supportiveness
- their contribution to the team climate or how the team works.

The process should help individuals clarify their work objectives, help them to feel valued, respected and supported, and help them identify the means to achieve any desired personal growth. It should also help the team mature in its team processes to be a high-functioning team (Richardson and West 2009).

References

Hackman JR (2002) Leading teams: setting the stage for great performances. Harvard Business Press, Harvard MA

Hackman JR, Wageman R (2005) A theory of team coaching. A*cademy of Management Review* 30 (2): 269–287

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In Salas E, Tannembaum SI, Cohen D, Latham G (eds) Developing and enhancing teamwork in organizations Jossey Bass, San Francisco CA: 331–372

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24 (6): 929–950

Richardson J, West MA (2009) Dream teams: a positive psychology of team working. In Lindley A, Harrington S, Page N (eds) Handbook of positive psychology and work. Oxford University Press, New York

Wageman R, Nunes DA, Burruss JA, Hackman JR (2008) Senior leadership teams: what it takes to make them great. Harvard Business Review Press, Harvard MA

West MA (2002) Sparkling fountains or stagnant ponds: an integrative model of creativity and innovation implementation in work groups. *Applied Psychology* 51 (3): 355–387

West MA (2012) Effective teamwork: practical lessons from organizational research. John Wiley and Sons, Chichester

West MA, Lyubovnikova JR (2013) Illusions of team working in health care. *Journal of Health Organization and Management* 27 (1) :134–142

West MA, Lyubovnikova J (2013) Illusions of team working in health care. *Journal of Health Organization and Management* 27 (1): 134–142

West MA, Markiewicz L (2004) Building team-based working: a practical guide to organizational transformation. Blackwell Publishing, Oxford

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management Oxford University Press, Oxford: 231–252

West MA, Markiewicz L, Shipton H (2006) HRM for team-based working. In Burke, RJ, Cooper CL (eds) The human resources revolution. Why putting people first matters. Elsevier, Oxford: 173–179

Shared leadership in teams

In organisations that emphasise a team-based approach, leadership becomes a collective activity emerging according to whoever has the most relevant skills for the task, rather than based on hierarchy or status.

What is it?

Shared (also known as 'collective') leadership in teams means everyone taking responsibility for leadership, depending on the situation, the task, their skills, motivation and the context. There may be a formal hierarchical leader, but everyone believes they play an important role in the leadership of the team, taking collective responsibility for making sure the team is successful in its work, functions well and supports the development and wellbeing of all team members.

Why is it important?

Given the challenges health services face in delivering care for patients, it is vital that all team members apply their knowledge, skills and capacity for co-operation and co-ordination within teams and across boundaries. This is particularly essential for developing or implementing new and improved ways of delivering services, promoting efficiency, improving quality or providing patient care.

Creating the right conditions for innovation involves giving frontline teams the autonomy to experiment, discover and apply new and improved ways of delivering care (Liu et al 2011, Somech 2006). Teams are most likely to meet their capacity for innovation when their members are given discretion, control and freedom, and when they embrace their responsibility for service improvement (Hirst et al 2011).

In this model, leadership becomes a collective endeavour rather than a designated hierarchical status that reflects an organisational chart.

If a team or organisation is to reach its potential, leadership needs to be linked to expertise. If someone has expertise in a particular area, they will take on more of a leadership role with a task that requires those skills. A team that links airtime with expertise in this way will have more effective decision-making. Also, because that individual's expertise is boosted with the authority of leadership, there is an improvement in team and organisational functioning.

This will also harvest the benefits of the synergies between managerial and clinical leadership. This is key to delivering high quality, safe care (Baker et al 2008).

This type of shared leadership is characterised by changes in leadership and followership, depending on the task at hand or challenges that unfold. There is still a formal hierarchy, with dedicated positions, but the ebb and flow of power depends on the situation, and on who has the expertise needed at each moment.

What is the evidence?

There is much evidence demonstrating that shared leadership in teams consistently predicts team effectiveness – particularly, but not exclusively, within healthcare (Aime et al 2014, Carson et al 2007, Hoch and Koslowski 2014, Pearce and Conger 2002, Wang et al 2014). Shared leadership in teams creates a culture that is more likely to deliver high quality, compassionate care. This is because all team members accept the distribution and allocation of leadership power to wherever the expertise, capability and motivation sit within the organisation.

There is one consistent lesson from investigations into failings in healthcare across the world. It is that safety depends on developing cultures in which all team members, at every level of an organisation, take responsibility for ensuring safe practice. This includes challenging unsafe behaviours, no matter the seniority of those involved (West et al 2014a).

So, regardless of the seniority of the medical consultant, if the healthcare assistant sees the consultant behave in a way that could harm patients, she will feel empowered to speak up. This requires that all team members recognise their leadership potential and responsibility – not as a quality of the individual, or their hierarchical status but as an inherent requirement in situations they may face each day.

Where quality in healthcare is not improving, it is almost certainly deteriorating (Berwick 2013). Shared leadership cultures can nurture high quality care by involving all team members in continual learning and quality improvement, using tools such as lean and six sigma. In shared leadership, everyone takes responsibility for quality, safety and patient experience. One natural consequence of this is a higher level of dialogue, debate and discussion across the organisation about how to improve quality of care (West et al 2014a). This dialogue can help achieve a shared understanding of quality problems and solutions.

Research and practice from the US Center for Creative Leadership suggests that collective or shared leadership in teams is more effective at creating direction, alignment and commitment – particularly in organisations that face challenges of uncertainty and complexity (Drath et al 2008):

- Direction involves agreeing what the team is seeking to achieve, such as care quality, good patient experience, compassionate care and staff and patient safety. It also means understanding and acceptance of how decisions are made in the team, and who makes them.
- Alignment refers to the co-ordination and integration of the work across the team so that care is appropriately integrated. Task and role clarity are key preconditions for alignment.
- Commitment refers to everyone taking responsibility for the success of the team as a whole, rather than focusing on just the success of their component of care.

How is it done?

Shared leadership in teams involves ensuring that leadership power is distributed to, and shared with, everyone in the team who has expertise, to ensure a move away from over-reliance on hierarchical leadership (McCauley 2011). It requires team members and leaders to adopt a common approach in which they overtly, consciously and collectively commit to:

- model compassion in dealing with patients and team members
- ensure the voices of all team members are encouraged, heard and acted on
- promote colleagues' engagement, participation and involvement as their core team behaviours
- promote a sense of cohesion, optimism and efficacy in the team
- help create a sense of psychological safety in the team through supportive, warm, humorous and respectful interactions
- promote autonomy and accountability for performance among team members (see Ensuring clarity of team roles)
- encourage each other to be proactive and innovative
- avoid domination, command and control, except in crisis
- take individual and collective action to address systems problems that hinder team members from working effectively
- surface and address intimidating behaviour or poor performance by team members towards patients or colleagues, regardless of seniority
- continually improve patient care or quality of services (for those who do not have direct patient contact)
- support innovation
- ensure that all groups are appropriately represented in the team (taking into account the size of the team) or organisation in terms of age, gender, ability or disability, sexual orientation and ethnicity
- collaborate supportively across internal or external departments or organisational boundaries
- engage all relevant team members in dialogue and in decision-making processes
- jointly formulate approaches and problem-solving with team members and leaders across the organisation to address chronic problems.

Tips

- Team members need to regularly review their success in developing shared team leadership and assess how far each team member is fulfilling each of the commitments listed above.
- Team members can regularly review their satisfaction with the level of shared leadership and what they might want to change.
- Powerful ways of developing shared leadership include reflective listening methods (for example, summarising others' contributions) and 'listening with fascination' to fellow team members.
- To create a climate for shared leadership, it is critical that team members value and have mutual respect for each other.

References

Aime F, Humphrey S, DeRue DS, Paul JB (2014) The riddle of heterarchy: power transitions in cross-functional teams. *Academy of Management Journal* 57 (2): 327–352

Baker GR, MacIntosh-Murray A, Porcellato C, Dionne L, Stelmacovich K, Born K (eds) (2008) High performing healthcare systems: delivering quality by design. Longwoods Publishing, Toronto

Berwick D (2013) A promise to learn – a commitment to act: improving the safety of patients in England. Department of Health, London

Carson JB, Tesluk PE, Marrone JA (2007) Shared leadership in teams: an investigation of antecedent conditions and performance. *Academy of Management Journal* 50 (5): 1217–1234

Drath WH, McCauley CD, Palus CJ, Van Velsor E, O'Connor PM, McGuire JB (2008) Direction, alignment, commitment: toward a more integrative ontology of leadership. *The Leadership Quarterly* 19 (6): 635–653

Hirst G, Van Knippenberg D, Chen S, Sacramento CA (2011) How does bureaucracy impact individual creativity? A cross-level investigation of team contextual influences on goalorientation – creativity relationships. *Academy of Management Journal* 55 (3): 624–641

Hoch JE, Kozlowski SW (2014) Leading virtual teams: hierarchical leadership, structural supports, and shared team leadership. *Journal of Applied Psychology* 99 (3): 390–403

Liu D, Chen X, Yao X (2011) From autonomy to creativity: a multilevel investigation of the mediating role of harmonious passion. *Journal of Applied Psychology* 96 (2): 294–309

McCauley C (2011) Making leadership happen. A white paper. Center for Creative Leadership, Greensboro NC

Pearce CL, Conger JA (2002) Shared leadership: reframing the hows and whys of leadership. Sage, London

Somech A (2006) The effects of leadership style and team processes on performance and innovation in functionally heterogeneous teams. *Journal of Management* 32 (1): 132–157

Wang D, Waldman DA, Zhang Z (2014) A meta-analysis of shared leadership and team effectiveness. *Journal of Applied Psychology* 99 (2): 181–198

West MA, Lyubovnikova J, Eckert R, Denis JL (2014a) Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance* 1: 240–260

West MA, Topakas A, Dawson JF (2014b) Climate and culture for health care performance. In Schneider B, Barbera KM (eds) The Oxford handbook of organizational climate and culture. Oxford University Press, Oxford: 335–335

Ensuring clarity of team roles

Role clarity means team members being clear, not only about their own role but also about the roles of their colleagues. This understanding enables team members to be collectively motivated, aligned and effective in their work.

What is it?

When people work in teams, there is a danger that not everyone will work effectively, because of poor team processes. Ensuring accountability for teamwork reduces this risk by clarifying the roles of team members. Doing this involves creating conditions that ensure team members take responsibility for their own performance and the performance of the team through:

- clear team objectives
- clear roles for team members
- regular reviews of performance.

Why is it important?

For teamwork to be effective, each individual needs to know how to function as a team member and must understand their responsibility for ensuring the effectiveness of the teamwork overall. A principal assumption behind the decision to structure an organisation around work teams is that teams make better decisions than individuals working alone. However, teams can fall prey to several social processes that undermine the effectiveness of their decision making:

- There is a powerful tendency to focus on the information that all team members share before a discussion starts, and to ignore new information that only one or two team members know about. For example, if everyone knows that a mother has asked for a natural birth but only one person in the midwifery team knows and mentions that there were quite serious complications in her last delivery, the information can easily be overlooked. This 'hidden profile' can be avoided by ensuring that (Stasser and Titus 2003):
  - members have clearly defined roles so that each is seen as a source of potentially unique and important information
  - members listen carefully to colleagues' contributions in decision- making
  - leaders alert the team to information held by only one or two members.
- Social conformity can cause group members to withhold opinions and information contrary to the majority view – especially if that view is the dominant one in the organisation (West 2012).
- The team may be dominated by particular individuals who take up disproportionate 'airtime' (the amount team members talk during a particular task) or argue so vigorously that their views prevail over those of their colleagues. It is worth noting that in high-performing teams, expertise and airtime tend to go together. In poorly performing teams, this is not the case (West 2012).

- Some members' contributions may be attended to or valued disproportionately if they have higher status (West 2012).
- Group polarisation causes work teams to make decisions that are either more risky or more conservative than the average of individual members' opinions or decisions (Semin and Glendon 1973, Walker and Main 1973).
- Groupthink can adversely affect the decision-making of tightly knit groups if they are more concerned with achieving agreement than with the quality of the decisions made. This phenomenon was identified by social psychologist Irving Janis in his study of failures in policy decisions. It is most likely to occur in teams with a dominant leader and/or where methodical decision-making procedures are not followed (Neck and Moorhead 1995).
- Social loafing is the tendency of individuals in teams to work less hard than they would if their individual contribution could be identified and evaluated. People may put less effort into achieving quality decisions in meetings if they perceive that their contribution is hidden in overall team performance (Karau and Williams 1993).
- A 'production-blocking' effect can inhibit individuals from thinking up new ideas and offering them out loud to the group, when everyone is vying to speak. A study of brainstorming groups shows that quantity, and often quality, of ideas produced by individuals working separately is consistently superior to those produced by a group working together (Diehl and Stroebe 1987).

What is the evidence?

The key to ensuring accountability for teams is to ensure clarity of team objectives and team roles. This summary focuses on ensuring clarity of team roles, but to find out more about setting team objectives, see Setting and using team goals.

When roles are clear, team members are more motivated, less stressed and perform better. Role ambiguity and role conflict are key factors in the development of work stress (Woods and West 2014).

When objectives and roles are clear, teams perform significantly better, with fewer errors, greater productivity and higher levels of innovation (West and Markiewicz 2016, West 2012).

Role stressors, such as role conflict, overload and ambiguity also have a negative impact on team performance (Rizzo et al 1970):

- Role conflict is found in a role that has competing goals – for example, in healthcare between quality of care and costs or among probation workers, for control versus support of clients.
- Role overload has a particularly significant impact on performance in healthcare (Wall et al 1997).
- Role ambiguity is a lack of clarity about the expectations of a team member's role, or those of other team members. Research has consistently shown links between these role factors and strain (Day and Livingstone 2001, Jackson and Schuler 1985, Netemeyer et al 1990).

How is it done?

Role clarity requires a team member to feel clear about their own role and those of their colleagues. This ensures direction for team members. Roles should be aligned to the purpose and objectives of the team. Knowing how one's role contributes to the overall purpose and objectives of the team ensures that each member is motivated and aligned. By understanding the necessity and value of their roles, team members become more committed to their work. So, role clarity exists when team members understand:

- how their work contributes to the overall team purpose
- what their role entails, and how this relate to the roles of other team members.

Teams may need to consider three different types of role clarity:

- role clarity between team members
- role clarity between professional groups in multidisciplinary teams
- role clarity about other teams in the wider team community – in other words, other teams that members need to cooperate with in the course of their work.

Tip: All team members need to be involved in taking time to review role clarity. For detailed guidance on clarifying roles in teams, go to: www.astonod.com

With this good practice in place, the team can conduct regular whole-team reviews. These must focus on ensuring each team member is effectively fulfilling their role. Creating a safe and supportive team environment is key to this.

The whole-team review can cover:

- each team member's role and responsibilities
- their successes in achieving objectives and fulfilling the roles
- areas where the team member, or other team members, wish they had been more successful
- factors in the team and externally (for example, in other teams) that have been helpful
- factors in the team and externally (for example, in other teams) that have been unhelpful
- changes needed in fellow team members in their roles to ensure success
- changes needed from the team leader
- changes needed in the individual in the focal role
- changes needed in the team as a whole
- changes needed in other teams
- changes needed in the organisation to ensure team effectiveness
- skill development or training needs for the individual
- any other issues.

Role design is also important and needs to take into account the motivating potential of each area of work (see Leader role job design).

Team roles and belonging

All individuals have a need to belong. At work, these needs are met mostly by stable team membership of effective teams. So, for example, rotation of junior doctors is likely to have a significant impact on their sense of belonging. Working in positive, cohesive, optimistic effective teams mitigates this to some extent. Working in dysfunctional teams will add considerably to stress levels and frustrations.

Key features of effective teams

- Having clear, agreed, challenging objectives
- Having clear roles
- Working and communicating together closely
- Meeting regularly and frequently to review performance and how it can be improved.

People's need to belong is met at work when they:

- have frequent and rewarding contact meet with key colleagues
- have a sense of long-term continuity and stability in their work relationships
- are not involved in chronic conflicts
- have a sense of mutual support and compassion in their workplaces.

Role reviews can also include an assessment of team members' teamwork knowledge, skills and abilities using self-reports and team members' 360 reports (see Selecting for team orientation, 360 feedback).

Case study

Aston OD provides examples of how teams have improved role clarity in the Aston Team Journey. These draw on presentations given by each individual or occupational group in the team about their work role, knowledge and skills on a regular basis. Their methods included:

- individuals shadowing fellow team members from other occupational groups, with clear objectives
- team members working together on new, shared projects requiring them all to make a contribution. Their reviews of the new knowledge of each other's roles and expertise resulted in significant changes to working practices
- teams circulating short work-related biographies of each team member when new team members joined
- team members developing a 'skills and knowledge' profile for each person and a description of their roles, with individuals tasked with ensuring that their profiles were kept current.
- team members using peer mentoring with team members paired up to co-mentor each other.

Source: www.astonod.com

References

Day AL, Livingstone HA (2001) Chronic and acute stressors among military personnel: do coping styles buffer their negative impact on health? *Journal of Occupational Health Psychology* 6 (4): 348–360

Dieh M, Stroebe W (1987) *Productivity loss in brainstorming groups: toward the solution of a riddle. Journal of Personality and Social Psychology* 53 (3): 497–509

Jackson SE, Schuler RS (1985) A meta-analysis and conceptual critique of research on role ambiguity and role conflict in work settings. *Organizational Behavior and Human Decision Processes* 36 (1): 16–78

Karau SJ, Williams KD (1993) Social loafing: a meta-analytic review and theoretical integration. *Journal of Personality and Social Psychology* 65 (4): 681–70

Neck CP, Moorhead G (1995) Groupthink remodeled: the importance of leadership, time pressure, and methodical decision-making procedures. *Human Relations* 48 (5): 537–557

Netemeyer RG, Johnston MW, Burton S (1990) Analysis of role conflict and role ambiguity in a structural equations framework. *Journal of Applied Psychology* 75 (2): 148–157

Rizzo JR, House RJ, Lirtzman SI (1970) Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly* [vol no?]: 150–163

Semin GR, Glendon A (1973). Polarization and the established group. *British Journal of Clinical Psychology* 12 (2): 113–121

Stasser G, Titus W (2003) Hidden profiles: a brief history. *Psychological Inquiry* 14 (3–4): 304–313

Walker TG, Main EC (1973) Choice shifts in political decision making: Federal judges and civil liberties cases. *Journal of Applied Social Psychology* 3 (1): 39–48

Wall TD, Bolden RI, Borrill CS, Carter AJ, Golya DA, Hardy GE, Haynes CE, Rick JE, Shapiro DA, West MA (1997) Minor psychiatric disorder in NHS Trust staff: occupational and gender differences. *British Journal of Psychiatry* 171: 519–523

West MA (2012) *Effective teamwork: practical lessons from organizational research.* John Wiley and Sons, Chichester

West MA, Markiewicz L (2016) Effective team work in health care. In Ferlie E, Montgomery K, Pedersen R (eds) *The Oxford handbook of health care management.* Oxford University Press, Oxford: 231–252

Woods S, West MA (2014) (2nd edition). *The psychology of work and organizations*. Sage, London

Team reflexivity and after-action reviews

Team reflexivity involves teams stepping back to review their objectives, strategies, processes and performance, and make changes accordingly. This practice leads to more productive, effective and innovative teams.

What is it?

Team reflexivity involves team members collectively reflecting on the team's objectives, strategies and processes, as well as their wider organisation and environment, and adapting accordingly. There is increasing interest in this approach because it is an effective way of developing teamwork generally (Schippers et al 2008, West 2000, Konrad et al 2015).

Team reflexivity has three stages or components (West 2000):

- reflection: a team's joint review of work related and social functioning (this is what a good sports team does at half time and at the end of the game)
- planning: detailed planning for change
- action or adaptation: implementation.

Reflexivity includes the concept of after-action reviews. These are reviews of specific team performance events or episodes to encourage reflection and self-discovery, target potential opportunities for improvement, and thus improve the quality and rate of learning (Tannembaum and Cerasoli 2013).

Why is it important?

One of the challenges for healthcare teams is very high workloads. With high workloads, teams need to be even more committed to taking time for regular reviews, to ensure their effectiveness.

In a study of 250 healthcare team members by Wiles and Robison (1994) three-quarters reported not having regular team meetings: most met each other only if there was a specific problem to be resolved. Similar findings were reported by West and Field (1995a,b) and Borrill et al (2000).

This means many teams continue to pursue goals and targets that are not appropriate for their context, such as reducing the time taken with each patient, as opposed to spending appropriate time with appropriate patients, as well as taking time out to reflect on their performance. Research on intensive care teams reveals relatively low levels of reflexivity (Piquette et al 2009a,b), despite evidence that nurses would prefer post-crisis feedback sessions to reflect on performance with other healthcare professionals (Piquette et al 2009a,b).

When team members collectively reflect on the team's objectives, strategies, processes and performance and make changes accordingly ('team reflexivity'), teams are more productive, effective and innovative (Widmer et al 2009, Konradt et al 2015). In contrast, non-reflexive teams show little awareness of team objectives, strategies and the environment in which they operate. Instead, they tend to rely on habitual routines that ultimately lead to poor performance, lack of innovation and inability to adapt to a changing environment.

This is particularly important for staff working in the NHS, given the medical errors can be attributable to poor communication and teamwork.

What is the evidence?

Evidence over the past 25 years (Widmer et al 2009, Schippers et al 2014, Vashdi et al 2007) shows that teams are much more effective and innovative in delivering patient care if they regularly take time out to:

- review what they are trying to achieve
- consider how they are going about it
- adapt their objectives and processes accordingly.

This was also the finding of a study of 98 primary healthcare teams. In teams with high workloads (patient-to-doctor ratio) or poor premises, those whose members took more time out to review their working methods were significantly more innovative than other teams (Schippers et al 2015). Reflexive teams also build self-awareness and monitor how members co-ordinate with one another. As a result, they are more likely to recognise areas that need attention and development and implement improvement plans accordingly (Tjosvold et al 2004).

Another good barometer of team performance is how effective a team is at managing errors. Team members and leaders can respond to an error either by seeking who to blame, or by asking 'What can we learn from this?'. Edmondson (1996, 1999) found that in nursing teams where members openly acknowledged and discussed their medication errors, there was learning about the causes of these errors as a team, and innovations were devised to prevent future errors.

Edmondson also found that learning and innovation only take place in teams whose members trust each other and believe that well-intentioned action will not lead the team to punish or reject them (Edmondson 2003, Edmondson et al 2007).

In a related area, two studies by Wiedow et al (2013) looked at how team learning processes affected on team outcomes (team co-ordination and overall team performance). They found positive significant effects between the use of team reflection and review on team outcomes.

Reflexivity can be improved through targeted training. Konradt et al (2015) conducted an experimental study of 98 teams investigating a reflexivity intervention. They found that the teams that had the reflexivity training demonstrated a greater capacity to reflect and share feedback and improved significantly compared with teams that had not had the intervention.

In another study, Vashdi et al (2013) highlighted the importance of structure, frequency and regularity of what they called 'reflection sessions' for optimum value. Their study, on 250 surgical teams, found that learning opportunities resulted in greater efficiency (in this case, quicker surgeries) and improved quality (fewer errors).

Another approach to increase reflexivity is to develop a process of debriefs and after-action reviews. A meta-analysis of 46 studies by Tannenbaum and Cerasoli (2012) explored the use of debriefs or after-action reviews to improve learning and performance. The review found that compared to controls, the use of debriefs improved effectiveness for teams and individuals alike, by an average of 25%.

How is it done?

Team reflexivity involves regular team reviews of issues such as:

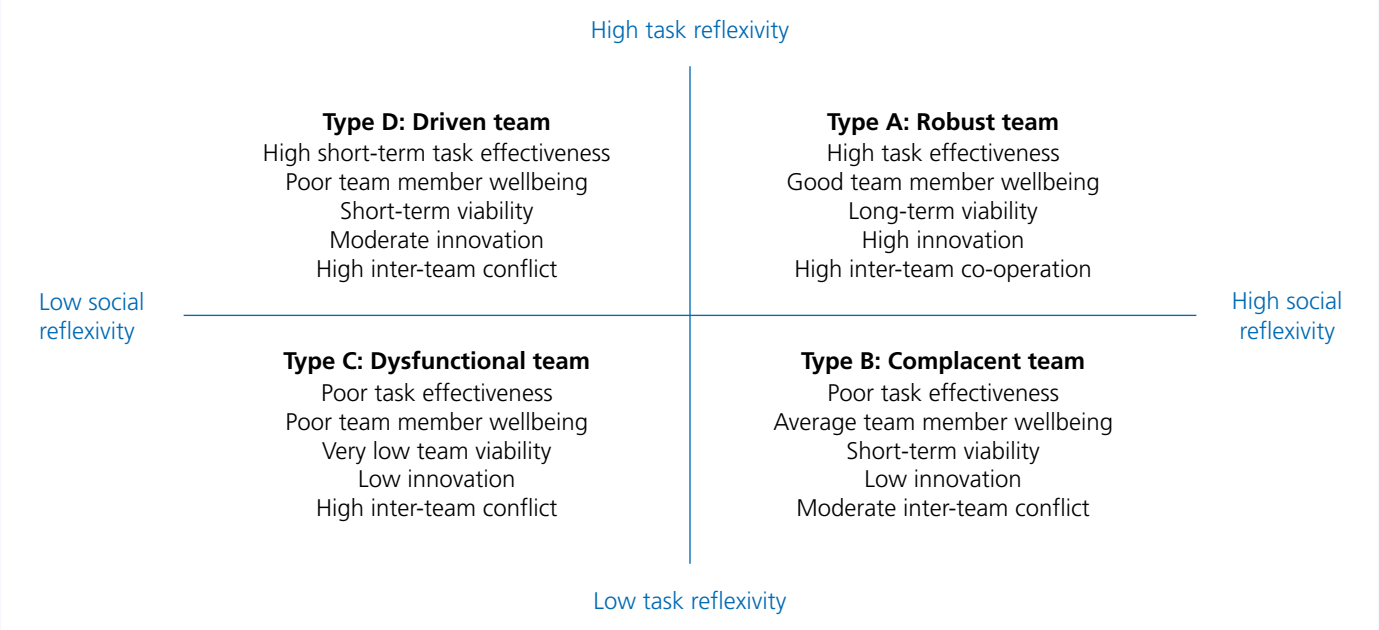
- the team's objectives, including an assessment of their continuing relevance and appropriateness, as well as progress towards their fulfilment
- errors, near misses or obstacles to the team's work, along with any concerns of team members vigilance among team members for external changes that could affect the team's work
- awareness, review and discussion of the team's functioning with a view to improving performance including:
  - performance against key outcomes
  - information-sharing
  - decision-making
  - meetings
  - management of conflict
  - management of innovation
  - communication
  - inter-team working
- team learning, levels of innovation, quality improvement, flexibility and adaptability
- clarity about roles
- collaborative working
- leadership including shared leadership
- team member satisfaction and wellbeing
- team positivity
- inclusion and members valuing diversity (including their different perspectives, knowledge bases, skills and experience).

Reflexivity can also be applied to the social factors that influence how members work together as a social unit. Teams are made up of people with a variety of emotional, social and other human needs. The team as a whole can either help meet these needs, or frustrate them. Feeling valued, respected and supported by other team members is a prerequisite for people offering their ideas for new and improved ways of ensuring team effectiveness.

Teams can reflect on their task. But they can also reflect on their social functioning – the ways in which they provide support to members, how they resolve conflicts and the overall social and emotional climate of the team (its 'social reflexivity'). Whether the team is reviewing task or social functioning, the purpose is to inform the next steps for appropriate adjustments to the team's objectives, ways of working or social functioning, in order to promote effectiveness. And there is evidence that such social interventions improve people's wellbeing and can improve performance (Daniels et al 2017).

Figure 1 shows these two elements of teams – the task and social element – drawn together in a two-by-two model. The figure illustrates four extreme types of team functioning. It then shows the likely effects upon the five principal outcomes of team functioning (West 2012):

- task effectiveness
- team members' mental health
- team viability
- innovation
- inter-team cooperation.



Type A ('the resilient team') represents a team that is high in both task and social reflexivity – in other words, it reflects on and modifies its objectives, processes, task and social support strategies appropriately in changing circumstances. This type of team is likely to have good levels of member wellbeing, high task effectiveness and sustained viability – in other words, the capacity and desire to continue to work together.

Type B ('the complacent team') is high in social reflexivity and low in task reflexivity. This is a team where there is a good deal of warmth, support and cohesion among team members, but less ability to get the task done effectively. Team members do not dedicate time to reflecting on the team's task objectives, strategies and processes, so they do not confront their performance problems, learn from mistakes or adapt their task performance to ensure effectiveness.

Type C ('the dysfunctional team') is the worst scenario – low on task and social reflexivity. This team fails to reflect on and change its functioning in either domain. It will not be viable in the long term, since leaders will be dissatisfied with both the interpersonal relationships and with the team's failures to achieve.

Type D ('the driven team') is one in which task reflexivity is high, but the social functioning of the team is poor. Members are driven to focus on achieving task objectives as quickly as possible with minimum distractions. Task performance is generally good in the short term, but poor social functioning damages team viability and the wellbeing of members.

Tips

- Carry out regular reviews of team reflexivity using the team reflexivity questionnaire
- Be prepared to challenge assumptions that are taken for granted within the team.
- Take the time to reflect on objectives, team roles, team processes and relationships rather than focusing exclusively on tasks.
- Ensure the process is engaging, fun, stimulating and vibrant rather than turgid and laborious.

References

Borrill CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, &West MA (2001) The effectiveness of health care teams in the National Health Service. Aston Centre for Health Service Organisational Research, University of Aston, Birmingham

Daniels K, Watson D, Gedikli C (2017) Wellbeing and the social environment of work: a systematic review of intervention studies. *International Journal of Environmental Research and Public Health* 14: 918–934

Edmondson A (1999) Psychological safety and learning behavior in work teams. Administrative Science Quarterly 44 (2): 350–383

Edmondson AC (1996) Learning from mistakes is easier said than done: group and organizational influences on the detection and correction of human error. *The Journal of Applied Behavioral Science* 32 (1): 5–28

Edmondson AC (2003) Speaking up in the operating room: how team leaders promote learning in interdisciplinary action teams. *Journal of Management Studies* 40 (6): 1419–1452

Edmondson AC, Dillon JR, Roloff KS (2007) Three perspectives on team learning: outcome improvement, task mastery, and group process. *Academy of Management Annals* 1 (1): 269–314

Field R, West M (1995) Teamwork in primary health care 2. Perspectives from practices. *Journal of Interprofessional Care* 9 (2): 123–130

Konradt U, Schippers MC, Garbers Y, Steenfatt C (2015) Effects of guided reflexivity and team feedback on team performance improvement: the role of team regulatory processes and cognitive emergent states. *European Journal of Work and Organizational Psychology* 24 (5): 777–795

Lyubovnikova J, West MA, Dawson JF, Carter MR (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of work and Organizational Psychology* 24 (6): 929–950

Miller A, Scheinkestel C, Limpus A, Joseph M, Karnik A, Venkatesh B (2009) Uni- and interdisciplinary effects on round and handover content in intensive care units. *Human Factors* 51 (3): 339–353

Piquette D, Reeves S, Leblanc VR (2009) Interprofessional intensive care unit team interactions and medical crises: a qualitative study. *Journal of Interprofessional Care* 23 (3): 273–285

Piquette D, Reeves S, LeBlanc VR (2009) Stressful intensive care unit medical crises: how individual responses impact on team performance. *Critical Care Medicine* 37 (4): 1251–1255

Schippers MC, Den Hartog DN, Koopman PL, Van Knippenberg D (2008) The role of transformational leadership in enhancing team reflexivity. *Human Relations* 61 (11): 1593–1616

Schippers MC, Edmondson AC, West MA (2014) Team reflexivity as an antidote to team information-processing failures. *Small Group Research* 45 (6): 731–769

Schippers MC, West MA and Dawson JF(2015) Team Reflexivity and Innovation: The Moderating Role of Team Context. *Journal of Management*, 41 (3): 769–788

Tannenbaum SI, Cerasoli CP (2013) Do team and individual debriefs enhance performance? A meta-analysis. *Human Factors* 55 (1): 231–245

Tjosvold D, Tang ML, West MA (2004) Reflexivity for team innovation in China: the contribution of goal interdependence. *Group and Organization Management* 29: 540–559

Tjosvold D, Tang MM, West M (2004) Reflexivity for team innovation in China: the contribution of goal interdependence. *Group and Organization Management* 29 (5): 540–559

Vashdi DR, Bamberger PA, Erez M (2013) Can surgical teams ever learn? The role of coordination, complexity, and transitivity in action team learning. *Academy of Management Journal* 56 (4): 945–971

Vashdi DR, Bamberger PA, Erez M, Weiss-Meilik A (2007) Briefing-debriefing: using a reflexive organizational learning model from the military to enhance the performance of surgical teams. *Human Resource Management* 46 (1): 115–142

West MA (2012) Effective teamwork: practical lessons from organizational research. Third edition. Wiley, Chichester

West M, Field R (1995) Teamwork in primary health care 1. Perspectives from organisational psychology. *Journal of Interprofessional Care* 9 (2): 117–122

West M, Field R (1995) Teamwork in primary health care 2. Perspectives from organisational psychology. *Journal of Interprofessional Care* 9 (2): 123–130

West MA (2000) Reflexivity, revolution, and innovation in work teams. In Beyerlein MM, Johnson DA, Beyerlein ST (eds) Product development teams. Stamford, Connecticut: JAI Press: 1–29

Widmer PS, Schippers MC, West MA (2009) Recent developments in reflexivity research: a review. *Psychology of Everyday Activity* 2 (2): 2–11

Wiedow A, Konradt U, Ellwart T, Steenfatt C (2013). Direct and indirect effects of team learning on team outcomes: a multiple mediator analysis. *Group Dynamics: Theory, Research, and Practice* 17 (4) 232–251

Wiles R, Robison J (1994) Teamwork in primary care: the views and experiences of nurses, midwives and health visitors. *Journal of Advanced Nursing* 20 (2): 324–330

Further reading

Center for Evidence Based Management

www.cebma.org/wp-content/uploads/Guide-to-the-after_action_review.pdf

This guide directs team to review action periods (for example, a ward shift) by asking these questions:

- What did we expect to happen?
- What actually happened?
- What went well and why?
- What could we improve and how?

The guide recommends that everyone should:

- be open and honest
- ensure professional discussion
- encourage participation by everyone on the team
- focus on the results of an event or project
- identify ways to sustain what was done well
- develop recommendations for how to overcome obstacles

How effectively does your team function in relation to reflexivity?

This questionnaire is designed for self-completion or completion by fellow team members.

Task reflexivity	Very inaccurate						Very accurate
1 The team often reviews its objectives.	1	2	3	4	5	6	7
2 We regularly discuss whether the team is working together effectively.	1	2	3	4	5	6	7
3 The methods used by the team to get the job done are often discussed.	1	2	3	4	5	6	7
4 In this team we modify our objectives in the light of changing circumstances.	1	2	3	4	5	6	7
5 Team strategies are often changed.	1	2	3	4	5	6	7
6 How well we communicate information is often discussed	1	2	3	4	5	6	7
7 The team often reviews its approach to getting the job done.	1	2	3	4	5	6	7
8 The way decisions are made in this team is often reviewed.	1	2	3	4	5	6	7
Total score:							

Task reflexivity	Very inaccurate						Very accurate
1 Team members provide each other with support when times are difficult.	1	2	3	4	5	6	7
2 When things at work are stressful the team is very supportive.	1	2	3	4	5	6	7
3 Conflict does not linger in this team.	1	2	3	4	5	6	7
4 People in this team often teach each other new skills.	1	2	3	4	5	6	7
5 When things at work are stressful, we pull together as a team.	1	2	3	4	5	6	7
6 Team members are always friendly.	1	2	3	4	5	6	7
7 Conflicts are constructively dealt with in this team.	1	2	3	4	5	6	7
8 People in this team are quick to resolve arguments.	1	2	3	4	5	6	7
Total score:							

Scoring

Add the scores for task reflexivity and social reflexivity separately.
Divide both totals by the number of people completing the questionnaire.

Values: task reflexivity

High scores: 42–56
Average scores: 34–41
Low scores 0–33

Values: social reflexivity

High scores: 42–56
Average scores: 34–41
Low scores 0–33

Outcome

Where the functioning seems low for no identifiable reason, discuss as a team how to improve it. This discussion can be a first step towards improving the team's reflections on its objectives, strategies, processes and social functioning to become a fully functional team.

From West MA (2012) Effective teamwork: practical lessons from organizational research. Wiley, Chichester

Building team-based working

Team-based working involves working within and between teams. This is especially important in healthcare organisations where teamworking is essential for integrated, high quality care.

What is this?

Team-based working is an approach to organisation design based on structuring work primarily around, and between, teams. In team-based organisations, teams rather than individuals make decisions, at the closest possible point to the service user, client or patient. For this, an organisation must support team and inter-team working in its culture and in its key organisation development and people management processes.

See also Teamwork training, Shared team leadership, Team-based appraisal.

Why is it important?

Teamworking in healthcare is often taken for granted, because teams and groups of teams must work interdependently to provide high quality care. However, we know that the quality of team and inter-team working in the NHS can be improved (West and Markiewicz 2016, Lyubovnikova et al 2015, Lyubovnikova and West 2013, West and Lyubovnikova 2013).

Poor teamworking leads to problems that include:

- errors that harm staff and patients alike
- injuries to staff
- poor staff wellbeing
- lower levels of patient satisfaction
- poorer quality of care
- higher patient mortality.

Establishing and developing team-based working is important precisely because many teams are dysfunctional and failing in the NHS. By identifying the causes of these failings, we can demonstrate how to develop proper team-based working.

They are:

- Teams without tasks and clear objectives – The point of having a team is to get a job done, a task completed or objectives met. Building teams simply to 'have teams' is likely to damage organisational functioning and encourage conflict, chronic anger and disruption. Once a team is identified, its tasks should be those best suited to teamwork. These should then be translated into no more than six to eight clear, agreed and challenging objectives.
- Teams without freedom and responsibility – Creating teams without the freedom and authority to make the decisions needed to accomplish their tasks is a recipe for failure. It is more dangerous to give teams too little freedom and responsibility than too much.
- Organisations deeply structured around individual work – In this scenario, teams are created but all the organisational systems are geared towards managing individuals. Creating team-based organisations means having an appropriate structure, support systems and culture.

- Team directors, not team leaders – Team leadership is different to traditional supervision. Supervisors are often directive, rather than facilitative, and offer advice rather than seeking it. They may try to shape rather than integrate views, and play a directive rather than supportive role. A leader's aim is different: to ensure the team achieves the maximum benefit through its combined knowledge, experience and skill.
- Strong teams in conflict – It is important to have co-operation and support between, as well as within, teams. If this is not a priority, a team can become a rigidly defended silo. For good team-based working, the organisation must establish and reinforce norms of co-operation between different teams.

What is the evidence?

Extensive research over 30 years has identified the value of team-based working for patient outcomes and staff wellbeing. Building effective team-based working is associated with:

- reduced staff turnover, absence and stress
- fewer errors and injuries
- less bullying, harassment and violence against staff.

It is also associated with better quality care and significantly lower patient mortality (West and Markiewicz 2016, Lyubovnikova et al 2015, Lyubovnikova and West 2013, West and Lyubovnikova 2013).

Case studies of organisations with team-based working reveal many benefits to organisational performance and patient outcomes. See Additional Information.

How is it done?

In practice, team-based organisations reflect a management philosophy incorporating these fundamental principles:

- promoting the development of shared objectives within the organisation
- involving all employees fully, by encouraging them to exchange ideas, views and information and increasing their influence over decisions
- building commitment to excellence and constructive debate
- developing a culture that supports creativity and innovation in the organisation.

Characteristics of traditional versus team-based organisations

Traditional approach	Team-based approach
Individual command structures	Collective structures
Manager controls	Team self-monitors
Vertical hierarchy	Horizontal integration
Stability and uniformity	Change and flexibility
One best way to organise	Organisation-specific ways of working
Managers manage	Self-managing teams

Six steps to developing team-based working

Step 1: Decide on team-based working

Before introducing team-based working, it is important to understand the existing structure, culture and extent of teamworking in the organisation. This stage also involves developing a plan for implementing team-based working. The process involves being clear about what is meant by a team.

A 'team' is a group of employees with these characteristics:

- shared objectives
- the necessary authority, autonomy and resources to achieve these objectives
- a need to work closely and interdependently to achieve these objectives
- well-defined and unique roles
- it is recognisable as a team
- no more than 10 to 15 members
- it regularly meets to review performance and consider how it can be improved.

Step 2: Develop support systems

This step involves examining support systems, such as training, human resource management (HRM) systems, communication and inter-team relations, and making plans to adapt or develop them for team-based working (see Developing appropriate support systems, on the following page for more detail).

Step 3: Select team leaders and team members

Next, establish criteria for selecting team leaders and members, and put appropriate recruitment and selection processes in place. Team leaders will need training, too. Leading teams is different to other kinds of leadership, so team leaders need to be equipped with the necessary knowledge, skills and attitudes.

Step 4: Develop effective teams

This step involves understanding and enabling the team development process. Actions include clarifying objectives, roles, communication and decision-making processes.

Step 5: Review and sustain team effectiveness

At this point, teams need to be coached to set criteria for evaluating team performance and to identify what changes are needed to improve performance.

Step 6: Review team-based working

The final stage is evaluating the contribution of team-based working to the organisation's effectiveness and making any changes needed, to ensure continued and optimal contribution.

Developing appropriate support systems

Making sure you have appropriate support systems is the key to team-based work. This section highlights areas an organisation needs to focus on to support effective team-based working:

- human resource management
- appraisal and performance review systems
- recruitment and selection systems
- education and training systems
- team process support systems
- inter-team processes.

We explain each in turn.

This section draws on West et al (2006). To find out more, read the full chapter 'HRM for team-based working' in The human resources revolution. Why putting people first matters.

Human resource management

Teams are created to develop ideas for improving their workplaces, work functioning, processes, products or services. However, climates of distrust, lack of communication, personal antipathies, limited individual autonomy and unclear goals can inhibit the implementation of these ideas.

The HR function plays a key role in creating a positive climate, but if it is to support a team-based rather than an individually based organisation, it has to be oriented strategically to that approach.

So members of the HR department will need to know about all aspects of teamworking, including team composition, team development, team processes and team performance management. They particularly need to understand inter-team processes and inter-team conflict and how to manage it.

Appraisal and performance review systems

When it comes to reviewing teams' performance, providing clear, constructive feedback offers great benefits. However, while individuals receive performance feedback, team performance is rarely evaluated.

Team-based organisations must devote considerable attention to developing performance criteria against which they can measure teams. These criteria need to go beyond simply evaluating team output, to include these effectiveness criteria in any set of team goals:

- team outcomes – for example, quality of care
- team viability – the team's sustained ability to work well together
- team member growth and wellbeing – team members' learning, development and satisfaction
- team innovation –introducing new and improved ways for the team to do things
- inter-team relations – co-operation with other teams and departments in the organisation.

However, team-based performance management does not replace individual performance management. Individuals still need regular, constructive feedback if they are to grow and develop in their jobs. But in team-based organisations, team performance review becomes the key focus, and this is enhanced by individual performance review.

Team peer review is more appropriate at team level, where numbers are not so large and where the most potent feedback is from peers rather than superiors or subordinates. See also Team appraisals.

Recruitment and selection systems
Team-based organisations take a slightly different approach to recruitment and selection. They focus these processes not only on individual and technical competencies, but on previous experience of working in teams, teamworking competencies and the motivation to work in teams.

Assessing candidates against generic team knowledge, skill and ability requirements has been found to be a relatively successful selection tool, and one that can enhance teams' effectiveness (Stevens and Campion 1999). See also Selection for team orientation.

Education and training systems
Implementing team-based working successfully is highly influenced by how far the organisation provides appropriate training for team members, team leaders and internal consultants working with team processes. Particularly in the early stages of a team's development, it is important to train team leaders and members alike. This should enable them to design and implement appropriate team processes and develop the skills for effective long-term teamworking Hackman 2002, West 2012). See also Teamwork training.

Team process support systems
Teams need help to establish and maintain effective teamworking processes . In team-based organisations, some teams will encounter difficulties with working effectively. This may arise because of unclear objectives or roles or, much more rarely, personality problems. To address this, some team-based organisations appoint an internal coach or external consultant. This may be described as 'process assistance' or 'process support' (Hackman and Wageman 2005).

See www.astonod.com

Inter-team processes
It is vital to assess teams on how far they co-operate with, and support, other teams in the team-based organisation. The strength of teamworking is that it involves everyone in contributing their skills and knowledge in good collective decision-making and innovation. A potential weakness is a tendency for competition, hostility and rivalry between teams.

Tips

- Approach team-based working as whole-organisation design, not as an add-on to the existing structure.
- Focus on developing team communities as well as good teamworking so that enthusiastic and effective inter-team working becomes the norm.
- Ensure the organisation evolves to be team-based over time, rather than individually oriented, by aligning systems and processes wherever possible.
- Regularly review the effectiveness of team-based working by drawing on the knowledge of teams across the organisation.

Additional Information

Examples of the benefits of team based working at organisations such as Merseycare NHS Foundation Trust, Birmingham Children's Hospital, North Staffordshire NHS Trust among others can be found at www.astonod.com/team-tools/aston-team-journey/

References

Hackman JR (2002) Leading teams: setting the stage for great performances. Harvard Business Press, Boston MA

Hackman JR, Wageman R (2005) A theory of team coaching. *Academy of Management Review* 30 (2): 269–287

Lyubovnikova J, West MA (2013) Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care In Salas E, Tannembaum SI, Cohen DI, Latham G (eds) Developing and enhancing teamwork in organizations. Jossey Bass, San Francisco, CA: 331–372

Lyubovnikova J, West MA, Dawson JF, Carter M R (2015) 24-Karat or fool's gold? Consequences of real team and co-acting group membership in healthcare organizations. *European Journal of Work and Organizational Psychology* 24 (6): 929–950

Stevens MJ, Campion MA (1999) Staffing work teams: development and validation of a selection test for teamwork settings. *Journal of Management* 25: 207–228

West MA (2012) Effective teamwork: practical lessons from organizational research. John Wiley and Sons, Chichester

West MA, Lyubovnikova JR (2013) Illusions of team working in health care. *Journal of Health Organization and Management* 27 (1): 134–142

West MA, Markiewicz L (2004) Building team-based working: a practical guide to organizational transformation. Blackwell Publishing, Oxford

West MA, Markiewicz L (2016) Effective team work in health care In Ferlie E, Montgomery K, Pedersen R (eds) The Oxford handbook of health care management. Oxford University Press, Oxford: 231–252

West MA, Markiewicz L, Shipton H (2006) HRM for team-based working. In Burke RJ, Cooper CL (eds) The human resources revolution: why putting people first matters. Elsevier, Oxford: 173–179

System leadership

This approach involves leaders taking a strategic view of entire healthcare systems, working alongside leaders from other organisations or sectors to find common ground and develop cultures and objectives aligned across organisational boundaries

What is this?

System leadership involves leaders working across boundaries within and between organisations and sectors, to ensure high quality integrated care and support for the communities they serve. This type of leadership requires specific skills founded in cross-boundary working, compassion and understanding of how to build belonging and trust.

Definition

Leadership across organisational and geopolitical boundaries, beyond individual professional disciplines, within a range of organisational and stakeholder cultures,often without direct managerial control. (The Virtual Staff College 2013)

Why is it important?

Compassionate leadership co-operation across boundaries is not only needed within individual organisations. Governments, practitioners and policy-makers increasingly agree that health and social care services must be integrated to meet the needs of patients, service users and communities efficiently and effectively. So as healthcare is delivered by an interdependent network of organisations, leaders must work together, spanning boundaries both within and between organisations, prioritising overall patient care rather than the success of their component.

That means leaders working collectively to build a co-operative, integrative leadership culture – in effect, collective leadership at the system level. This requires cross-boundary relationships that are not only effective but trusting.

New structures requiring systems-level collective leadership

New care models
www.england.nhs.uk/2017/02/new-care-models/

Sustainability and transformation plans
www.kingsfund.org.uk/topics/integrated-care/sustainability-transformation-plans-explained

Accountable care systems
www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained

However, collaboration is not always easy. At present, competition is still encouraged, the way the NHS is organised remains fragmented, and regulators often operate inconsistently. NHS organisations are also under extreme pressure to meet targets for services and reduce financial deficits.

In this context, it can be tempting for organisations to look after their own interests and performance rather than to work in partnership with others. But this is a major missed opportunity to transform care delivery in ways that meet the population's changing needs. If NHS organisations want to improve services and make the best use of limited resources, they need to work together with their partners (Ham and Alderwick 2015).

What is the evidence?

The evidence points to practical ways in which leaders can work together across boundaries to address challenges. It includes The King's Fund's work on:

- developing new care models (Collins 2016)
- sustainability and transformation plans (Ham et al 2017, Alderwick et al 2016)
- accountable care organisations (ACOs) (Addicott et al 2014).

It is also informed by The King's Fund's work on the experience of people who have occupied system leadership roles (Fillingham and Weir 2014, Timmins 2015). Practical case studies with leaders seeking to make a success of working in new care models, sustainability and transformation partnerships and accountable care systems, has informed understanding of system leadership.

Five factors in particular (drawing on Hewstone and Swart 2011 and Baumeister and Leary 1995) help frame the challenges system leaders face. We describe these in the next section, which draws on research literature, case studies and The King's Fund's research and organisational development work (Hulks et al 2017, West and Chowla 2017).

How is it done?

The five principles for system leadership are:

- developing a shared purpose and vision
- ensuring frequent personal contact
- surfacing and resolving conflicts
- behaving altruistically towards each other
- committing to working together for the longer term.

We explain each of these over the following pages.

Developing a shared purpose and vision

Systems leaders must develop together a compelling shared vision of transforming the health and wellbeing of communities. So a key step in developing system leadership involves shifting from reactive problem-solving to building positive visions for the future.

This typically happens as leaders help staff and communities articulate their deeper aspirations and build confidence based on tangible accomplishments achieved together. This shift involves not just building inspiring visions, but facing difficult truths about the present reality and learning how to use the tension between the vision and that reality, to inspire truly new approaches (Senge et al 2014).

Example: Focusing on people and places, not organisations

Greater Manchester Combined Authority has made more progress than most, with its strategic plan agreed around a year before STPs were introduced in the rest of England. This happened as part of its devolution agreement with the government (AGMA et al 2015). The plan was developed on the principles of co-design and collaboration, and focuses on people and places rather than the organisations that deliver services. It is a practical example of the shared purpose and vision needed to underpin system leadership.

Greater Manchester also has leadership and governance arrangements to support joint working. Frequent personal contacts between leaders in local government and the NHS helped in this process.

Many involved in new care models and sustainability and transformation plans invested time in developing a shared purpose and vision. This made them confront difficult choices about the present reality while working towards 'inspiring visions'.

Ensuring frequent personal contact

Leaders who need to work together must have frequent personal face-to-face contact, to build trust and make progress. Collaboration is a team activity that cannot be conducted at a distance. Face-to-face meetings help establish the rapport and understanding on which collective leadership hinges.

Leaders need to address issues that may seem basic, such as whether they understand each other sufficiently to forge alliances and whether mutual trust exists or can be developed. Collaboration also means understanding the person behind the role and the different, as well as shared, motivations and interests that exist among those seeking to collaborate.

Reflection and conversation enable leaders to see different points of view and appreciate each other's reality, emotionally as well as cognitively. This requires leaders to take time to get together regularly – not only meeting when there is business to be done.

Example: Building a shared approach

One STP group held weekly conference calls and monthly face-to-face meetings to deal with business matters. But when the local authority and NHS leaders decided to put aside an afternoon and evening to spend together, they found they made rapid progress tackling some complex issues.

They held exploratory discussions about how they could work together in very different ways in future. They also worked on specific issues, and had time to delve into each other's understanding of the risks and opportunities those offered. For example, they considered how to better integrate services for children and young people and for the local adult population. They also discussed how they could take a more active approach to improving the local population's health.

The group agreed to meet in this format every six weeks.

Surfacing and resolving conflicts

The journey to collaboration and collective leadership is rarely straightforward. As in all relationships, agreements go hand in hand with disagreements. And if these are allowed to fester and undermine relationships and trust, they can be fatal. For this reason, systems leaders need a shared agreement to surface and resolve conflicts quickly, fairly, transparently and collaboratively.

However, an absence of conflicts can be more worrying than their presence. This is because conflicts arise when difficult truths are confronted rather than suppressed. So conflicts and challenges should be welcomed as a step towards system leadership, while recognising that persistent conflicts can also be damaging.

It helps if leaders have agreed a common approach to conflict management, such as the Thomas Killman

model of conflict management style. The more they collaborate to solve problems, the stronger the working relationships will become.

See www.kilmanndiagnostics.com/overview-thomas-kilmann-conflict-mode-instrument-tki

Behaving altruistically towards each other

System leadership requires system leaders to overtly commit to behaving altruistically towards each other's organisations. This means mutually supporting the success of the whole system, to transform communities' health and wellbeing.

Baumeister and Leary (1995) suggest that leaders who can behave altruistically towards others can play a key role in developing collective leadership. This means approaching relationships with peers by asking, 'How can I help?' and not 'How can I use our relationship to further my own position and that of my organisation?' It also means approaching collaboration by asking not, 'How can I win in this discussion?' but rather 'How can we succeed together?'

Example: Coming together to oversee commissioning decisions

In Salford, the CCG and the local authority created an integrated commissioning committee to oversee commissioning decisions for all adult health and care services. They hope that by discussing how to meet the population's needs, they will make progress in developing altruism and mutuality and avoid 'the tragedy of the commons', which occurs when self-interested behaviour works against the common good (Hardin 1968).

Committing to working together for the longer term

System leaders must avoid focusing only on short-term objectives. They need to build a shared commitment to working together for the medium and long term, to engender a sense of long-term continuity and stability in the systems network. Collaboration is more likely when leaders know their partners are committed to working together for the longer term. This matters, because building effective relationships requires considerable time and energy. Leaders may calculate that this investment is worthwhile only if there is reasonable certainty their collaborators are likely to be ongoing partners in transforming the systems for which they are jointly responsible.

Part of the system leader's role is to share the picture of the future in their own organisations and not shy away from the changes' possible impact. Inevitably, leaders often encounter cynicism. It is often borne of frustration and a sense of 'being done to'. Building an understanding of the long-term possibilities and engaging people in shaping the plans takes time. And it is that investment that makes the difference.

Example: local government and the NHS working together

Manchester's 'Living longer, living better' programme is an example of progress in developing system leadership between local government and the NHS, with a focus on long-term aspiration (described by Fillingham and Weir 2014). The programme is overseen by the health and wellbeing board, which comprises NHS and local government commissioners and key statutory providers in the city.

The 'engine room' is the city-wide leadership group comprising key leaders from partner organisations. This group captured the vision for Manchester as being 'living longer, living better' (Manchester City Council 2013). The partners have worked together to create a compelling narrative that makes sense to frontline staff and local citizens.

Bringing these factors together

Peter Senge et al (2014) argue that when it comes to intractable global challenges such as climate change, youth unemployment and poverty, system leadership is the only approach that works. But it often flounders because leaders to do not embrace the truth that transforming systems is ultimately about transforming relationships among people who shape those systems.

Effective system leadership means being open to hearing and acting on different points of view. This, in turn, depends on creating time and space for partners to have the conversations that create a foundation for understanding and change. It requires these qualities, identified by Timmins (2015) in a study of system leaders:

- prioritising consultation, engagement, persuasion and influence rather than hierarchical power
- being able to walk in other people's shoes
- identifying those who will form a coalition of the willing
- the ability to persuade people to own ideas that they may not have thought of as their own.

Example: Long-term commitment to system leadership

Faced with a growing and ageing population, and the prospect of having to build a second acute hospital to cope with rising demand, leaders in Canterbury, South Island, New Zealand committed to working together as 'one system, one budget' even though they had neither a single system nor one budget.

The district health board acted as a catalyst, bringing together clinicians, managers and other stakeholders to plan future services. Through extensive engagement across the community, the partners agreed a shared vision of a single integrated health and social care system in which patients were at the centre. The work not only helped avoid a new hospital being built by 'bending the demand curve', but enabled the system to manage a succession of earthquakes that destroyed the centre of Christchurch and damaged healthcare facilities. Independent analyses demonstrated the district health board's achievements compared to other health boards in New Zealand (Timmins and Ham 2013) and the way in which integrated care helped moderate the growth in demand for acute care (Schluter et al 2016).

To find out more, go to: www.kingsfund.org.uk/audio-video/david-meates-place-basedhealth-care

This summary was adapted from Hulks S, Walsh N, Powell M, Ham C, Alderwick H (2017) Leading across the health and care system. The King's Fund, London

References

Addicott R, Walsh N, Ham C, Shortell S (2014) Accountable care organisations in the United States and England: testing, evaluating and learning what works. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england (accessed on 20 April 2017)

Association of Greater Manchester Authorities (AGMA), NHS England, Greater Manchester Association of Clinical Commissioning Groups (2015). Greater Manchester health and social care devolution: memorandum of understanding. AGMA, NHS England and Greater Manchester Association of Clinical Commissioning Groups, Manchester

Alderwick H, Dunn P, McKenna H, Walsh N, Ham C (2016) Sustainability and transformation plans in the NHS: how are they being developed in practice? The King's Fund, London. Available at: www.kingsfund.org.uk/publications/stps-in-the-nhs (accessed 20 April 2017)

Baumeister RF, Leary MR (1995) The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin* 117 (3): 497

Collins B (2016) New care models. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/new-care-models?gclid=EAIaIQobChMIro253ISO1gIVzLDtCh2QNA4OEAAYASAAEgJKp_D_BwE

Exceptional leadership for exceptional times, synthesis paper. Cited in NHS Leadership Academy (2017) Developing systems leadership - interventions, options and opportunities.

Fillingham D, Weir B (2014). System leadership: lessons and learning from AQuA's integrated care discovery communities. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/system-leadership (accessed 20 April 2017)

Ham C, Alderwick H (2015) Place-based systems of care: a way forward for the NHS in England. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/place-based-systems-care (accessed 10 August 2017)

Ham C, Alderwick H, Dunn P, McKenna H (2017). Delivering sustainability and transformation plans: from ambitious proposals to credible plans. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/delivering-sustainability-and-transformation-plans (accessed 20 April 2017)

Hardin G (1968). 'The tragedy of the commons'. Science 162 (3859): 1243–1248

Hewstone M, Swart H (2011). Fifty-odd years of inter-group contact: from hypothesis to integrated theory. *British Journal of Social Psychology* 50 (3): 374–386

Hulks S, Walsh N, Powell M, Ham C, Alderwick H (2017). Leading across the health and care system. The King's Fund, London. Available at: www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Leading%20across%20the%20health%20and%20care%20system.pdf

Manchester City Council (2013). Living longer, living better: an integrated care blueprint. Paper presented to health and wellbeing board, March. Available at: www.manchester.gov.uk/ meetings/meeting/1886/health_and_wellbeing_board (accessed 20 April 2017).

Schluter P, Hamilton G, Deely J, Ardagh M (2016) Impact of integrated health system changes, accelerated due to an earthquake, on emergency department attendances and acute admissions: a Bayesian change-point analysis. BMJ Open (6): e010709. Available at: http://bmjopen.bmj.com/content/6/5/e010709 (accessed 10 August 2017)

Senge P, Hamilton H, Kania J (2014) The dawn of system leadership. Stanford *Social Innovation Review* winter: 27–30

Timmins N (2015) The practice of system leadership: being comfortable with chaos. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/practice-system-leadership (accessed 10 April 2017)

Timmins N, Ham C (2013) The quest for integrated health and social care: a case study in Canterbury, New Zealand. The King's Fund, London. Available at: www.kingsfund.org.uk/publications/quest-integrated-health-and-social-care

West MA, Chowla R (2017). Compassionate leadership for compassionate health care In Gilbert P (ed) Compassion: concepts, research and applications. Routledge, London: 237–257

Additional useful resources

Further resources which will help your work in this area

Do OD have a range of resources available on their website including this team toolkit: www.nhsemployers.org/case-studies-and-resources/2014/07/do-od-team-toolkit

London Leadership Academy have a number of pages on their website featuring tools, guides and resources on leading teams: www.londonleadershipacademy.nhs.uk/leadershiptoolkit/leading-teams-and-change/leading-teams

Health Education England, West Midlands and East Midland and the NHS Leadership Academy and NHS Leadership Academy East Midlands have produced this guide to inclusive Talent Management www.hee.nhs.uk/sites/default/files/documents/Inclusive-Talent-Management-Handbook-2014-Second-Edition.pdf

HEE West Midlands developed an STP OD Tool with their STP OD and leadership SROs and Deloitte to support the West Midlands STPs and all stakeholder organisations to consider the strengths and development needs to successfully deliver their plans. improvement.nhs.uk/resources/culture-leadership

Case Study 17

Who
East London NHS Foundation Trust

Programme name
Developing a high performing human resources team

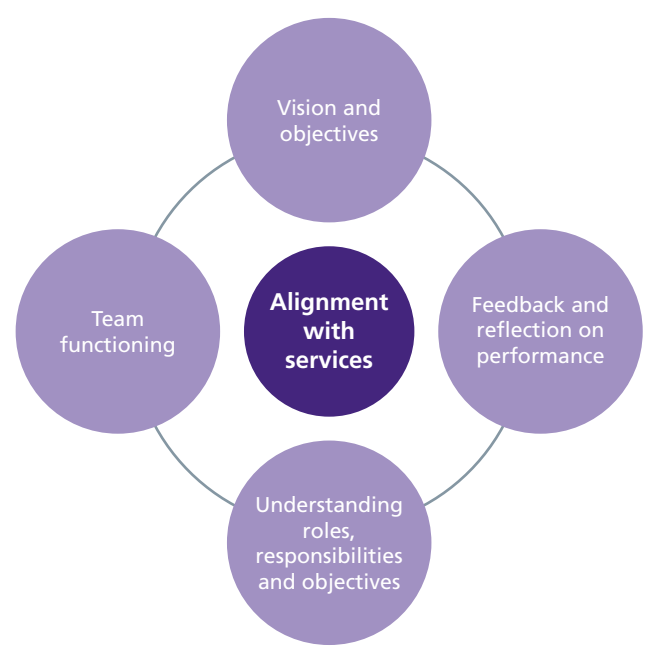
What was the aim?

We restructured our human resources directorate to support a business partnered human resources model and resolve the fragmentation, silos and variation in connection across the wider directorate arising from having eight sub-teams and a variety of bases for team members. Following this we needed to improve teamworking and alignment with clinical services.

What did we do?

An extended leadership team was brought together to identify the areas for improvement, one of which was teamworking. This team included team leaders, associate directors, business partners and senior advisors.

Using the evidence base from Michael West's research we developed a model for teamworking.



Exploratory questions for each of these five areas and a semi-structured interview were developed. Each member of the extended leadership team was interviewed for about 30 minutes and asked questions such as:

Vision and strategic objectives

- Are we clear about the overall direction?
- Do individuals buy into this vision?

Team functioning

- Do we understand how our contribution counts toward achieving the vision?
- How good are we at ensuring diverse voices are heard and contributions valued?
- Are conflict levels healthy and do we manage conflict well?

- How do we interact – do the formal structures and informal processes work well?
- What do we reward in our team?
- Do we believe we can succeed?
- Are we optimistic as a team?

Understanding roles and responsibilities and objectives

- Are roles and responsibilities clear in the new structure?
- Do they enable growth and personal development?
- Do we have the right level of co-operation with other teams we interact with?

Team performance and feedback

- How do we know we provide services that meet the needs of our clients?
- What feedback mechanisms do we use and how effective are these?

Alignment with services

- How well do we understand the core business of the trust and how our work contributes to patient care?
- How do we keep close to the business so that we understand their needs?

The feedback was collated in preparation for a half-day workshop on the emerging issues.

What were the outcomes?

More work was needed to explain the role of the HR business partner, how this impacts on the rest of the directorate and how we need to work differently. Continued clear articulation of the vision and greater clarity about performance objectives at team level were also flagged. Team functioning had improved following our restructure and there was a real commitment to building on this.

Early indicators of improved team functioning include increased communication across teams, greater team problem solving and more multispecialty meetings to build on objectives aligned to service delivery.

Feedback from the team includes:

- Linkage with strategic agenda and how we can better support the business and its strategic objectives/changes.
- It was helpful to have external facilitator for this to collate our feedback in confidence.
- Helps to:
  - promote teamwork and build stronger relationships
  - encourage open communication
  - create a forum for us to meet, share updates and work more collaboratively
  - ensure the whole team is 'on the same page' and creates a sense of collectiveness and shared vision/work
  - bring us together as a team
  - identify clear roles and responsibilities
  - provide an element of 360 degree feedback
  - allow us to work on key priorities and objectives and align these with the business objectives
  - stimulate communication and transparency
  - encourage and promote inter/cross teamworking.

What was the learning?

- Invite your team's internal/external stakeholders to join might be useful
- Have an agenda/action list for each meeting and link this back to your daily work and objectives

- Have follow-up meetings with other team members to cascade information and link with their work
- Have an external facilitator to help you formulate ideas constructively
- Meetings need to be regular to keep the learning and participation active
- All need to attend meetings to contribute effectively
- Interactive activities help formulate ideas
- Being open and honest makes meetings more meaningful.

For further information please contact:
Sandra.Drewett@elft.nhs.uk

NHS Improvement

Contact us

NHS Improvement
Wellington House
133–155 Waterloo Road
London
SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

 Publication code: IT 07/17