



# The impact of leadership factors in implementing change in complex health and social care environments: NHS Plan clinical priority for mental health crises resolution teams.

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# EXECUTIVE SUMMARY

In summarising the findings of this national, longitudinal study of the relationship between quality of leadership in Mental Health Crisis Resolution Teams (CRTs) and both staff attitudes and well-being, and organisational performance, we would like to address three principal questions:

- What did we set out to achieve?
- What did we find?
- What are the implications?

## **What did we set out to achieve?**

1. The development of CRTs over the past decade, and the policy initiatives to mainstream these crises services across England, presented an ideal backdrop against which to examine policy implementation and the impact of leadership on the functioning and performance of these teams.

Consistent with the Department of Health Mental Health Policy Implication Guidelines (MHPIG), the teams were selected with reference to the Durham Mapping database, such that they: - were multi-professional in their composition; operated 24/7, 365 days of the year; and delivered services in the patient's home or community. The additional inclusion criterion of being in operation for at least 6 months was imposed.

2. The purpose of the investigation was to undertake longitudinal research to examine the relationship between quality of leadership and both staff attitudes to work and their well-being at work, and organisation performance, allowing for the effect of a wide range of contextual factors.
3. This was achieved through collection of a combination of quantitative and qualitative data, including 8 detailed Case Studies.
4. The principal hypothesis was: that the quality of leadership exhibited by CRTs is directly related to team effectiveness.

Team effectiveness, which was defined in two ways: (1) staff attitudes to work and sense of well-being at work; (2) organisational performance, was tested through a series of subordinate hypotheses.

5. Complete data were available for a total of 46 mental health crisis resolution teams (CRTs) from different parts of England.

## *Review of the literature*

6. In order to ensure that an appropriate model of leadership was adopted, an extensive review was undertaken of the relevant literature.

Our understanding of the history of the formal academic research into the nature of leadership is that it can be seen to have developed through 5 main stages: the 'trait' or 'Great Man' approach; the 'behavioural' approach, out of which the concept of managerial and later leadership competencies emerged; the 'situation' or 'contingency' approach; the 'new paradigm' approach, with its focus on 'distant' transformational, often 'heroic' leadership; and finally, the emergence of 'nearby' transformational or 'engaging' leadership, and the associated concept of 'distributed' leadership.

7. It was suggested that it is valuable to distinguish two aspects of leadership – 'what' a leader does, and 'how' they do it.

The first of these, as exemplified by the NHS 'Leadership Qualities Framework', the police 'Integrated Competency Framework', and the fire and rescue service 'Personal Qualities and Attributes', can be seen to reflect leadership competency, which may be defined as follows:

A competent leader is someone who enables the development of an organisation in a way that is *goal directed*, and geared to developing *processes and systems*. This enables staff at all levels to *plan effectively and efficiently*, in order to *achieve agreed goals*.

High levels of competency can lead to a *degree of consistency* within an organisation or department, and thereby enable staff to make *day-to-day decisions* and *short-term predictions*, with a measure of *confidence*.

Leadership competencies, which are often largely closed-ended in nature, are necessary in order that staff can undertake both *strategic and day-to-day planning*, and in this way help to turn the *vision* of an organisation, department or team *into a reality*.

The second of these may be defined in the following way:

A transformational or *engaging leader* is someone who encourages and enables the development of an organisation that is *characterised by a culture* based on *integrity, openness and transparency*, and a *genuine valuing of others*.

This shows itself in concern for the development and *well-being of others*, in the ability to unite different groups of stakeholders in articulating a *joint vision*, and in delegation of a kind that *enables* and develops potential, coupled with the *encouragement of questioning* and of *thinking which is critical* as well as *strategic*.

Engaging leadership is essentially open-ended in nature, enabling organisations not only to *cope with change*, but also to

be *proactive in shaping their future*. At all times, 'nearby' transformational behaviour is guided by *ethical principles*.

Recent research in the US, UK and more widely, has pointed to the significant impact of an engaging style of leadership on organisational performance among a wide range of medium to large-size companies. Research conducted in the NHS and local government in the UK, (and replicated in FTSE 100 companies) that was inclusive of gender, ethnicity, and level, has provided a robust metric, of proven validity, for assessing this kind of leadership behaviour.

8. Another important conclusion was that transformational or engaging leadership behaviours cannot be assessed as if they were some kind of 'add on' to an existing 'competency framework'.

The reasons for this stem in part from the criticism that competency frameworks provide an overly 'reductionist', fragmented account of leadership behaviour. As two American writers recently put it,

"What matters is not a person's sum score on a set of competencies, but how well [or as we would put it, *in what way*] a person uses what talents he or she has to get the job done." (Hollenbeck *et al.* 2006).

Two similes are relevant here. Alimo-Metcalfe and Alban-Metcalfe (2005) suggested that anyone could paint a Monet if one could deconstruct a beautiful painting into a 'painting by numbers' exercise.

Bolden and Gosling (2006) offered a musical simile:

"a competency framework could be considered like sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life."

9. To paraphrase an expression used by Neil Kinnock,<sup>1</sup> when properly constructed, leadership competencies can be likened to Brighton Pier, very fine in their own way, but not a good way of getting to France. The conclusion drawn here can be summarised as follows: neither competent nor engaging leadership should be seen as superior to the other; rather, they should be seen as complementary, with the suggestion that leaders should lead competently, in a transformational or engaging way.
10. Increasingly, organisations concerned with the need to build internal leadership capacity, are moving towards the notion that it is not so much about a what leader **does** but rather **a process** that engenders

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<sup>1</sup> When describing the Special Education Act (1981).

leadership behaviours in others'. Indeed, this purpose is a central feature of the nature of 'engaging leadership'.

11. A complementary way of interpreting the leadership research is to suggest that the development of leadership competencies results in an increase in 'human capital', which, through the enactment of engaging behaviours, can be turned into 'social capital'. This has implications for leadership development.

*Data collection:*

12. The 'Leadership Climate & Change Inventory (LCCI)<sup>TM</sup> was used to assess the quality of leadership. The LCCI comprises two sets of items, those that assess the competency or 'leadership capability' of a team, and those that assess transformational or engaging leadership behaviours. The LCCI also assesses twelve facets of attitudes to work and well-being at work.
13. Following a visits to each of the 100 CRTs that originally agreed to participate in the study, the LCCI was administered to all staff, under conditions that ensured complete anonymity.
14. In order to ensure the validity of the LCCI in the present context, the responses from 731 staff were factor analysed. The emergent structures suggested the existence of three scales. Two of these, which were labelled 'Engaging with Others' and 'Visionary Leadership', assessed different aspects of transformation or engaging behaviour; the other was labelled 'Leadership Capability'.
15. Contextual data were collected in relation to the following factors: -the proportion of service-users diagnosed as showing symptoms of psychosis; the Mental Illness Needs Index (MINI) for the locality; the availability of alternatives to in-patient provision; the age of the team; the number of staff who deal with a given service user; the extent to which the team had gate-keeping control over in-patient admissions; the amount of dedicated clinical support available to the team; the extent to which the team was multi-disciplinary; and the extent to which the team offered 24/7, 365 day cover.

Some of this information was collected from the team lead, either during the initial visit, when the nature and purpose of the study was explained, or subsequently from the team. The other information was obtained from official statistics.

16. Organisational performance was assessed in four ways: 'ratio' – the number of assessments made by a team to the number of referrals for inpatient care as an average over a twelve month period; 'change' – defined as any differences in the 'ratio' over a 12-month period; 'productivity' – calculated by dividing the 'ratio' scores by the number of

members of the team; and 'change in productivity' – defined as an differences in the 'ratio' over a 12-month period.

It should be pointed out that whilst defining organisational performance in this way is open to criticism, such a definition is wholly in line with the criteria consistently adopted by the Department of Health.

17. A questionnaire-based, semi-structured interview was conducted with each of the team leads, which was designed to assess their approach to change management and identify which, if any, models of change management they used.
18. Extensive Case Study data were collected on the basis of detailed, one-to-one discussions with the members of eight teams, including the team lead, and with external agents who worked in association with the teams.

Of the teams selected, five were categorised as 'high performing', in terms of having a low assessments/referrals ratio, and three as 'low performing'.

### **What did we find?**

#### *Relationship between leadership and staff attitudes and well-being:*

19. Leadership quality, as measured by each of the 3 scales, was significantly positively correlated with each of the 12 facets of staff attitudes to work and their well-being at work. In other words, the leadership behaviours categorised as 'Engaging with Others', 'Visionary Leadership, and 'Leadership Capability', had a positive effect on staff.
20. Further analysis of these relationships revealed strong predictive links between 'Engaging with Others' and each of the 12 facets, and between 'Visionary Leadership' and 6 of the facets, and 'Leadership Capability' and 4 of the facets. This suggests that leadership behaviours that involve 'engagement' have much the greatest impact on staff's attitudes to work and their well-being at work.

#### *Relationship between leadership and organisational performance:*

21. At the level of whole teams, there was some evidence to suggest that organisational performance, defined in terms of 'ratio' scores (ratio of assessments to referrals), but not when defined in terms of 'change' scores, was positively associated with 'Engaging with Others'.

No such relationships were found involving either 'Visionary Leadership', or 'Leadership Capability'.



22. At the level of individual team members, 'productivity' ('ratio' in relation to number of staff), but *not* 'ratio', 'change', or 'change in productivity', was significantly related to 'Engaging with Others', when the effect of the nine contextual factors had been taken into account.

No such relationships were found involving either 'Visionary Leadership', or 'Leadership Capability'.

*Relationship between contextual factors and organisational performance:*

23. Again, when the data were analysed at the level of individual team members, it was evident that certain of the contextual factors assessed had a significant effect on organisational performance.

'Productivity' was affected positively by the staff/case ratio, the number of different staff involved in working with a given service user, whether the team performed a gate-keeping role, and whether alternatives to inpatient care were available. Conversely, 'productivity' was related negatively to the age of the team, the amount of medical cover available, and the proportion of service users presenting symptoms of psychosis.

*Relationship between leadership, contextual factors and organisational performance:*

24. The relationship between leadership, the contextual factors that were studied, and organisational performance, was examined in two ways, hierarchical multiple regression analysis and structural equation modelling. The first of these is designed to determine the *relative* strengths of the impact that each contextual or leadership variable has on the outcome (organisational performance). The second, structural equation modelling, specified alternative ways in which the different variables interact both with one another, and with the outcome.
25. Both sets of analysis suggest: (1) that 'Engaging with Others' (but not either 'Visionary Leadership' or 'Leadership Capability') has a significant impact on the 'productivity' of teams; (2) seven of the nine contextual variables have a significant impact on 'productivity', some positive, others negative; and (3) that the impact of some of the contextual factors is greater than the impact of the leadership behaviours identified as 'Engaging with Others'.

Put simply, this suggests that, while certain kinds of leadership behaviour, specifically that characterised as 'engagement' does have a significant effect on organisational performance, contextual factors too can be demonstrated to have a significant impact. Also, the impact of some of the contextual factors studied was positive, others negative.

However, when the effects of contextual variables are controlled for, 'engaging leadership' does predict/explain **additional unique variance**

in performance effectiveness of the team. That is, (irrespective of the effect of contextual variables), engaging leadership had a significant impact **over and above** that predicted by contextual variables

26. These observations are borne out by the Case Study data to the extent that both leadership behaviour and contextual factors affect organisational performance. However, what the Case Study data also point to are: (1) that contextual factors other than those that were the subject of quantitative analysis can have an impact on organisational performance; and (2) that in some situations, such contextual factors can have an influence that supervenes quality of leadership in a team.

*Change management:*

27. An hypothesised link between quality of leadership and a transformational approach to change management proved impossible to test. This was largely owing to practically all team leads describing the approach they had adopted as transformational in nature.
28. What this part of the study did reveal, however, was that teams leads appeared to used models of change that they themselves did not overtly recognise as having any particular theoretical base.

*Case Studies:*

29. Analysis of the Case Study data resulted in the emergence of a number of themes. These included: relationships within the team and with external agencies, including the impact of contextual factors; attitudes to change; the experience and confidence of team members; and team structure and leadership.
30. The extent to which teams were successful in achieving their targets, depended to a very great extent on the nature and quality of the relationships they had with a range of external stakeholders with whom they have to operate. Where mutually-agreed protocols had been drawn up, this tended to be beneficial to the smooth-running and effectiveness of the team.

Linked to this, there was a perceived need both for better definition of the boundaries between the responsibilities of different agencies (CRTs, CMHTs, GPs, A&E, &c.) working with different groups of service users, and for adherence to boundaries and protocols. Related to this, contextual factors (including those referred to here), over which the team has no control, were seen to have a supervening influence on the functioning and performance of teams.

31. Many teams expressed the need to have a greater sense of stability, though it was also evident that change can be a stimulus to greater achievement. Good leadership was seen to be effective in overcoming resistance to change.

32. Teams were conspicuous in making effective use of human and material resources, which were often limited.
33. Where medical models of provision were seen to dominate, they could have a deleterious effect on performance.
34. With regard to team structure, teams were seen to work best where there were 'flat' hierarchies, and 'whole team' approaches were adopted in dealing with issues. Related to this, having a senior management team that tended to be remote from the rest of the team, particularly in the case of larger teams, had a debilitating effect on the functioning of the team.

Furthermore, team leads were seen as more credible when they showed that they too were able to work directly with service users;

35. Two aspects of staff intrapersonal attitudes, and the way they should carry out their duties emerged. One was that the extent to which different team members were willing to take risks was related to their personal confidence, which was, in turn, related to the nature of, and the amount of, experience that they had, and the support available within the team.

The other was teams' attitudes to inpatient care. Specifically, whether or not they regarded admission as an absolute last resort appeared to be relevant to admission rates.

36. 'Good leadership', including having a vision, networking, and managing in an efficient and supportive way, was seen as fundamental to the effective functioning of teams.
37. Lastly, it was recognised that 'good leadership' on its own does not guarantee low admissions rates.

#### *Overview of findings:*

38. Overall, the results indicate that, while the three aspects of leadership studied were positively associated with staff attitudes and well-being, to a greater or lesser extent, only 'engaging' leadership behaviours were a significant **predictor** of organisational performance.
39. Furthermore, both the quantitative and qualitative data point to the significant effect of contextual factors on organisational performance.

#### **What are the implications?**

##### *Implications for health practitioners:*

40. The importance of good quality leadership in any health service cannot be emphasised enough. One of the key findings from the current study demonstrated this by revealing a significant relationship between good quality leadership and the effective functioning of a CRT.
41. Good leadership, more specifically engaging with others, was also important in predicting positive staff attitudes towards work and well-being at work. The significance of this for practitioners includes the importance of feeling self-confident and having the discretion to take decisions within a well-defined structure.
42. Equally important, is the creation of a work environment in which staff feel empowered, are supported by their manager, have opportunities for development, and are highly motivated and satisfied with their job.
43. A further implication for practitioners derives from the concept of shared or distributed leadership, and the acknowledgement that all team members play some part in the leadership culture of the team and its potential to operate successfully.
44. The findings, therefore, emphasise the importance of leadership as a shared or 'distributed' process.

*Implications for managers:*

45. The relative prominence of the Team lead appeared pivotal to a well functioning team, and demonstrates the importance of an engaging approach to leadership in this particular person. Being an experienced practitioner, as well as an effective manager, emerged as crucial requirements for success in the role of Team lead. Some also had postgraduate training.
46. The impact of good leadership as identified by team members revealed how a supportive, collaborative, visionary and a pragmatic approach to managing a CRT was highly effective in terms of maintaining good staff morale, developing a sense of purpose, having clarity of role, and creating good internal and external working relationships.

*Policy implications and implications for new ways of working:*

*Leadership development*

47. Change is an inherent feature of health care services, and good leadership is essential for ensuring that it is well managed. CSIP/NIMHE (2007) recognises the need for effective leadership to enable the 'New Ways of Working' in mental health become a reality.
48. Policy makers need (1) to recognise that managers and clinicians/professionals need *practical* guidance in how to approach managing change, and (2) to focus on the kind of leadership

development that goes beyond developing human capital, and addresses the issue of how best to also develop social capital, such that leadership becomes **embedded** in the culture of the team..

49. Iles and Preece (2006) pointed to fundamental differences between 'leader development' and 'leadership development' when they noted that,

“Leader development refers to developing individual-level intrapersonal competencies and human capital (cognitive, emotional, and self-awareness skills for example), while leadership development refers to the development of collective leadership processes and social capital in the organization and beyond, involving relationships, networking, trust, and commitments, as well as an appreciation of the social and political context and its implications for leadership styles and actions.”

50. If there is one message that comes across strongly, both from the review of the literature, and the empirical findings, it is that an engaging style of leadership is crucial to achieving success. The implications of this include questioning whether leadership development programmes that rely exclusively on developing 'leadership competency' can be regarded as fully 'fit-for-purpose'.

Leadership competencies can be effective in guiding leader development, and thereby increasing human capital, but an engaging style of leadership is what enables the release of human capital, and the creation of social capital.

#### *Policy implementation and the introduction of new services*

51. Service development policies should not be too prescriptive, as with the case of the MHPIG (1999); prescriptive policies ignore the local context and, as such, enforce teams to conform to a model that may not best fit their requirements. As such, policies should describe the reasons and desired outcomes of change rather than providing very detailed instructions on how the change should be achieved.
52. Human resource considerations: when introducing a new service, policy makers should consider the best means by which to create positive attitudes amongst staff, generating a sense of purpose, ownership and commitment to work.
53. HR professionals play a key role in building leadership capacity, by being actively involved in advising and scrutinising current selection, promotion, leadership development, and appraisal processes adopted by organisations, to ensure that they not only include competencies, but also most importantly, advocate the adoption of 'engaging transformational' approaches to **how** the competencies are enacted.

They should also be informed so that they can influence and 'educate' their colleagues as to why this is so important to the business of the quality of delivering healthcare.

54. A 'whole systems' approach to service provision was found to be a key element of successful inter-agency working; such an approach should be promoted as it is evident that good relationships between different agencies are crucial to improving crisis care.
55. Policy makers should reconsider the outcomes or performance targets expected of mental health services, such as admissions to hospitals, focusing instead on staff and service user satisfaction and other indicators of good quality mental health care.

*Technical considerations:*

56. **The fact that this study was longitudinal in design, is of critical importance, since this has enables conclusions to be drawn not only about 'associations' between a range of variables, but also about the nature of causal relationships between these variables over time.** As far as we are aware, this is the first investigation of its kind that has demonstrated the impact of the precise nature and quality of leadership on both: staff attitudes and well-being, and on organisational performance, when the effect of a wide range of contextual factors has been taken into account.
57. **The findings from this study add significant weight to the increasing disquiet being expressed in a number of recent publications to the preoccupation with describing leadership purely in terms of 'competencies'.**
58. Technically, this research takes the model of 'engaging' transformational leadership on which the LCCI was developed, to the forefront of understanding of what exactly an engaging style of distributed leadership looks like in daily interactions in teams.

# SECTION 1 – LEADERSHIP AND ORGANISATIONAL CLIMATE

The development of Mental Health Crisis Resolution Teams (CRTs) over the past decade, and the policy initiatives to mainstream these crisis services across England, presented an ideal backdrop against which to examine policy implementation and the impact of leadership on team function and performance. In the first section we review the literature on leadership and organisational climate. This is followed by a section on the development of crisis resolution teams from conception to implementation.

The present section provides a brief overview of leadership research with respect to its definition, the methodologies adopted, and the conclusions drawn. It then considers some of the most recent commentaries which have focused on the emergence of the (relatively new) paradigm of 'post-heroic' leadership. Finally, the literature on leadership is related to that on organisational culture and climate, and there is discussion of the relationship between the two phenomena.

## LEADERSHIP

Since leadership first became the subject of systematic study, the models of leadership that have emerged have changed over time, as have the *foci* of leadership research. This is, not least, because notions of what is regarded as leadership have been affected fundamentally by factors in society. This has contributed to some confusion, as has also the fact that researchers have adopted a variety of definitions of leadership, and methodologies for its study.

Thus, for example, some researchers have focused on studying *who leaders are* and *on what leaders do*, specifically, through the identification of those personal attributes which differentiate those individuals who are perceived as leaders, or who act in the role of leader. Conversely, others have focused more on what leaders *do*, and *how* they do it. Thus, more recent research has focused attention on the *relationship* between leaders and followers, which has come to be seen as the study of *leadership* behaviour, rather than just leader behaviour. In parallel, some writers have stressed the need to study followership, not only because all leaders are also followers, but also because modern notions of leadership place considerable emphasis on the power and importance of followers in ultimately enabling leadership to have greatest effect (e.g., Hollander, 1978; Lee, 1993).

Most recently, there has been a significant growth in the argument that leadership should be conceptualised as a 'distributed' practice' throughout the organisation, and not the sole domain of those in appointed positions (e.g., Jackson, 2006; Spillane, Halverson & Diamond, 2001).

For reasons that are discussed, it is important to understand the nature of leadership in the 21<sup>st</sup> century, as well as the provenance of any model of

leadership, in order to be able critically to appraise the value of the concept of leadership and how it can validly be assessed.

Formal studies of leadership, which date back to the first half of the 20<sup>th</sup> century, can be seen to have developed through five identifiable stages. During the first three of these, leadership was seen as a process that (a) involves influencing others, (b) occurs within a group context, and (c) results in goal attainment (Northouse, 2004). More recently, however, definitions of leadership have emphasised the need for leaders to enable the organisation to adapt to a constantly changing and increasingly complex environment, and the role of leader as 'defining organizational reality' (Bryman, 1996). In all cases, the emphasis has been on identifying those factors that make certain individuals particularly effective in influencing the behaviour of other individuals or groups and in making things happen that would not otherwise occur or preventing undesired outcomes (Rosenbach & Taylor, 1993). They can be seen culminate in the concept of shared or 'distributed' leadership.

### **Stage 1: Trait Approach**

This approach, often referred to as the 'Great Man' or Trait approach because such individuals were often the focus of attention, was based on a general acceptance that what differentiates leaders from non-leaders, or followers, is certain enduring personal characteristics or 'traits' (e.g., Alimo-Metcalfe & Alban-Metcalfe, 2002; Northouse, 2004; Wright, 1996). Thus, it was suggested that the possession of characteristics such as energy, dominance, intelligence, which were regarded largely in-born, and thus enduring, were seen as essential for 'leadership'. Such characteristics, it was claimed, could be used to predict effectiveness in a variety of situations.

However, two important reviews of the literature by Stodgill (1948) and by Mann (1959) were widely interpreted as concluding that there were, in fact, no consistent findings in relation to the personality characteristics that differentiated leaders from non-leaders, or more effective from less effective leaders.

Thus, for example, Mann reported ninety-one studies which showed a significant positive relationship between leadership status and intelligence, but a further ninety studies where no such relationship was detected, and one study which revealed a negative relationship. Stodgill concluded that the qualities, characteristics and skills that a leader needs to possess are, to a large extent, determined by demands of the situation in which he (or she) is to function. However, he later wrote that, while both personality and situational factors are involved, it is possible to identify a number of relatively consistent personal characteristics associated with appearing leader-like. These include: a strong drive for responsibility and task completion, being original and venturesome, self-confidence and sense of personal identity, and ability to influence others' behaviour and to structure social interaction systems. It is, however, the combination of characteristics that is important: the possession



of certain characteristics in abundance, if in the absence of certain other characteristics, may be a recipe for failure.

This had the effect of diverting attention away from studying who leaders *are*, and towards what they *do*.

### **Comment**

One of the major potential benefits anticipated by the early leadership researchers, was that if a consistent relationship were found between personality and appearing leader-like – that is, being seen as emerging as a leader in a group with no formally appointed leader – then personality measures could help organisations improve their selection processes. Although, in principle, the idea was, and still is, undoubtedly appealing to organisations, it was soon recognised that no single personality, or other personal characteristic such as intelligence, could consistently predict a leader emerging, or being accepted by members of a group. It is the combination of various characteristics, together with characteristics of the *situation* which needed to be taken into account when attempting to select individuals for leadership roles.

The effect of Stodgill's and Mann's findings was the abandonment of personality studies, though more recently, Bass (1998) has suggested that, in certain combinations, a pattern of personality traits may account for as much as 35% of variation. This view is supported by the findings of Church and Waclawski (1995) who found that managers classified as 'motivators' were seen as more likely to encourage risk-taking, to maintain a challenging and motivating work environment, and to take time to celebrate accomplishments, while 'inventors' were significantly better at innovating, setting direction, and establishing a sense of mission about their work, but were only average at influencing followers by arousing their hopes, enthusiasm, and energy.

Although one of the strengths of the trait approach was that it focused on the leader component of leadership, it can be criticised for failing to take into account the effect of situational factors. Traits that may make a person an effective leader in one situation may not do so in another. Two further criticisms are that, in spite of it being intuitively appealing to identify 'leadership traits', the list of such traits is almost unending, and that the approach did not offer possible avenues for training and development.

### **Stage 2: Behavioural Approach**

Thus in the 1950s, the attention of psychologists investigating leadership, switched from focusing on the personal characteristics of leaders, to the *behaviour* of individuals who influenced followers. Typically, such behaviour was described as the 'leadership' or 'managerial style' adopted by the leader. Of the number of research studies in this area, the most famous were those undertaken by the researchers at the Ohio State University where Stodgill worked (Alimo-Metcalfe & Alban-Metcalfe, 2002; Northouse, 2004; Wright,

1996). Towards the end of this period, development of the concept of 'managerial competencies' (McClelland, 1973) first emerged.

The main approach was to administer questionnaires to the subordinates/direct reports of individuals in supervisory positions. In these, the subordinates were asked to respond to a battery of statements about their observed supervisor's/manager's behaviour. The questionnaires typically measured 'managerial' or 'leadership style' by a combination of scores on two separate dimensions. These dimensions have been described in various ways, but can be summarised as a concern for the task, and a concern for the people undertaking the task.

Although well over thirty different models have been devised, most can be described in terms of four styles: (1) concern for task – also called 'task-orientated', or 'production-centred'; (2) concern for people – also called 'person-orientated', or 'employee-centred'; (3) directive leadership – also called authoritarian, or autocratic; (4) participative – also called democratic. In some studies, styles such as directive and participative were represented as discrete types of leadership, in others, they were regarded as opposite poles of a single dimension. The justification for identifying opposite poles was that leaders rarely act in ways that are, for example, simultaneously directive and participative. As has been pointed out, an individual may be highly participative in one situation, but highly directive in another.

In other studies, only concern for task and concern for others were investigated, either as different types of leadership, or as opposite ends of one dimension. A third approach, adopted in the Ohio State University studies, used two composite dimensions, 'consideration' (concern for people merged with participative) and 'initiating structure' (concern for task merged with directive), which they regarded as independent of each other (e.g., Fleishman, 1953; Halpin & Wiver, 1957; Fleishman & Harris, 1962). Being high or low on one of the dimensions was seen not affecting measured on the other dimension. Unfortunately, however, while the 'consideration' behaviours of a leader (supervisor/manager) were found to correlate positively with employee satisfaction, they were negatively correlated with the productivity of the manager's group (Stodgill, 1974).

One of the most popular practical outcomes of these style theories of leadership was the Management Grid (1964) developed by US psychologists Black and Mouton which provided a two-dimensional grid based on concern for people, and concern for results, which provided descriptions of the styles which characterised a variety of combinations on the grid. However, despite the descriptions provided by Blake and Mouton for the four segments of the grid, they clearly advocated the position which represented a combination of high scores on both dimensions. A further approach was to collapse all four styles into a single leadership dimension, which ranged from participative and person-centred to directive and task-centred, from which a single 'leadership score' was calculated (Wright, 1996).

## **Comment**

The main contribution of this period of leadership research was to emphasise the benefits of two major components in leadership style – concern for people and concern for the task. Methodologically, the approach adopted in most of these studies was sound in that ratings were based on the perceptions of direct reports, though the items were imposed by the researchers.

A small number of studies were conducted to establish cause-effect relationships between leadership style and outcome (or 'criterion') variables, such as productivity, errors made, labour turnover, absenteeism, stress, job satisfaction, but the results were inconsistent. Reasons for this may include a failure to take account of the effect of any interaction between subordinate behaviour and performance, on the way in which the leadership style was manifested. Other factors likely to determine whether or not one style is superior to another are the nature of the criterion variable chosen, and the extent to which two or more criterion variables interact with one another.

In common with the trait theorists, the advocates of the behavioural approach assumed that one combination of leadership behaviours would lead to successful leadership, regardless of the situation, an assumption which lacks consistent empirical support. However, rather than abandoning this approach, situational influences were incorporated into their theories.

The approach was valuable in that it broadened the focus of leadership research to include the actual behaviours that leaders show, and in that distinctions were drawn between task-related behaviour and relationship-related behaviour. It also provided a tool for self-analysis, which had the potential for informing training and development. It was not, however, able to show how leadership behaviours are linked to performance outcomes, nor did it succeed in identifying a 'universal style' that would be effective in most situations.

However, the major omission of this research was the lack of consideration given to situational variables which affect the appropriateness of a particular style. Answers to questions such as, Does the leader need the full commitment of his/her staff to achieve success in a particular activity/project? Is there only one way of achieving the task successfully? Does the leader have all the information necessary to achieving success? Is there a time constraint on achieving an outcome? To what extent does the degree of the authority given to the manager to ensure the task is achieved affect the manager's success? These relate to issues which undoubtedly affect the effectiveness of a manager's approach to leading and influencing the behaviour of their staff, and are not addressed.

### **Stage 3: Situational and Contingency Approaches**

This realisation led to the development of a variety of new models of leadership, which dominated the 1960s and 1970s and which came to be

known as situational or contingency theories of leadership. These approaches were predicated on the belief that different situations require different kinds of leadership, and that effective leaders are those that are sensitive to subordinates' needs, and adapt their style to the demands of different situations (Alimo-Metcalfe & Alban-Metcalfe, 2002; Gill, 2006; Northouse, 2004; Wright, 1996).

Examples include the classic model developed by Fiedler (1967), known as Fiedler's 'Contingency Model', which placed specific emphasis on three situational variables: the position power of the leader, the degree to which a task is structured, and the quality of leader - member relationships. Other models which became popular are: House's path goal theory of leadership (House, 1977; House & Dessler, 1974, the 'Leader-Member Exchange' (LMX) theory (Graen & Cashman, 1975), the Vroom and Yetton (1973) 'Normative Model' of leadership behaviours which linked various options in leadership style to clear situational criteria, and the model which was to become, probably, the most well-known training situational leadership model amongst practising managers – the Hersey and Blanchard (1969) 'Situational Leadership Model'.

Fiedler's Contingency theory suggests that leadership performance can be only be understood in relation to the context in which it occurs, and that success is achieved when there is a leader-situation match. Unlike other theorists of this time, Fiedler believed that a leader's style is relatively inflexible, thus there is a need to match leaders to a particular role, rather than expect a leader to vary his/her style in different situations. The theory provides a framework for analysing styles and situations, though the inner workings of the theory are unclear, and some writers have disputed the model's validity has (e.g., Bass, 1990). Other criticisms concern the methodology of measuring leadership style through the Least Preferred Co-worker (LPC) scale created by Fieldler, and the nature of the supporting evidence (Ashour 1973; Schriesheim & Kerr 1977; Vecchio 1977).

In Path-Goal theory, the emphasis is on the relationship between leadership style and the characteristics of both the subordinates and the work setting. The underlying assumption was that subordinate motivation would be greater if they, (a) thought themselves capable of doing their work, (b) believed that a certain outcome would result from their effort, and (c) regarded the payoffs as worthwhile. Although path-goal theory is conceptually complex, it is essentially concerned with the way in which leader behaviour, subordinate characteristics, and task characteristics affect the path between subordinate activity and organisational goals.

The approaches discussed so far tend to treat subordinates in a collective way, i.e., as a group, and suggest the use of a single, average leadership style. In contrast, Leader-member exchange (LMX) theory advocates recognition of individual differences between them, and an emphasis on dyadic relationships between a leader and each of her/his subordinates. Early studies focused on the quality of leader-subordinate interaction, and led to the distinction between 'in-group' and 'out-group' communication. In-group

communication would characteristically be richer in content, resulting in negotiation of role responsibilities, whereas out-group communication would be more formal, and lead to more closely defined roles. In-group subordinates would tend to receive more information, influence, confidence, and concern from their leader. More recently there has been evidence of a relationship between LMX scores and job satisfaction, though there is still disagreement as to exactly how LMX scores should be calculated (van Breukelen, Schyns & Le Blanc, 2006).

The Vroom-Yetton (1973) Normative model was concerned with subordinates' participation in decision-making and the effectiveness of such decisions, in the relationship between amount and form of participation. Two types of decision process were involved: - decisions affecting the entire teams and decisions affecting only one subordinate. Problems were analysed with reference to twelve attributes, with each rated on a five-point scale. On the basis of a mathematical formula, suggestions for leader behaviour are made.

Thus, for example, Hersey and Blanchard devised their Situational Leadership model to assess, (a) leadership style, and (b) subordinates' developmental level. Leadership style was defined with reference to two dimensions: directive behaviours, and supportive behaviours. Combinations of high *versus* low scores were used to identify four styles, which were labelled: directing (high-low), coaching (high-high), supporting (low-high), and delegating (low-low).

Similarly, subordinates were categorised into one of four groups in terms of two dimensions – commitment and competence – but with explicit recognition that employees can move backward as well as forward along a developmental continuum. The model specifies which leadership style is appropriate for each developmental level.

### **Comment**

Some situational models have been proved to be of practical value in training and development, particularly because of their emphasis on the need for adaptability and flexibility on the part of the leader, and on the need to interact differently with subordinates according to the nature of the task.

General criticism centres on the paucity of research to justify some of the assumptions made, and the prescriptions proposed. This is reflected in a failure to define precisely some of the terminology used. Contingency theory is supported by much empirical research, and has broadened understanding of the impact of situations on leaders, but it fails to explain fully why some styles are more effective than others. Another general criticism of some situational and contingency models is that they are confusing and difficult to apply.

More recently, such theories have been interpreted more as measures of 'management' than of 'leadership'.

#### **Stage 4: 'New paradigm' Approaches**

The late 1970s and early 1980s marked a watershed in the history of leadership. It was pointed out that, while the situational and contingency models provided guidelines for dealing with complexity, and for achieving greater efficiency, they offered little advice as to how to approach leadership in an environment of continuous and significant change (Hunt, 1999). Mintzberg (1982), in particular, wrote a scathing critique of the irrelevance of leadership research to practising managers.

It was in this climate that the 'new paradigm' approaches to leadership emerged (Bryman, 1992). These comprised the 'visionary' (Sashkin, 1988), 'charismatic' (House, 1977; Conger, 1989; Conger & Kanungo, 1988), and 'transformational' models (Bass, 1985; Tichy & Devanna, 1986). Situational models of leadership which preceded the emergence of the new leadership, came to be referred to as models of 'traditional' (Hunt, 1999), or 'transactional' (Bass, 1998) leadership, or of 'management' (Kotter, 1990). It was pointed out that, while they provide valuable information as to how to plan, organise, create order and structure, at times of relative stability, they are not sufficient for leading organisations through times of rapid change. The term 'transactional' is adopted because the leader's/manager's influence is as a result of exchanging rewards, in the form of praise or sanctions, in return for desired performance.

One of the first comparisons between models of transactional and transformational leadership was articulated not by a psychologist, but a political scientist – James McGregor Burns (1978), who developed his model based on Weber's (1947) seminal work on charismatic leaders. Burns described some politicians as characterised as "heroic", in that "leaders and followers raise one another to higher levels of morality and motivation" (cited in Hunt, *op. cit.*, p. 20). Burns believed that by engaging the followers' higher needs, leaders which he described as 'transformational' move followers beyond their self-interest, and towards working for the greater good. He also believed that in doing so, they become self-actualising, and become leaders themselves.

Burns contrasted such individuals with the type of politician who trades promises for votes, that is, those who influence followers by transactions of exchange: "Pay, status, and similar kinds of rewards are exchanged for work effort and the values emphasised are those related to the exchange process" (Hunt, 1996, p. 187).

US psychologist and leadership scholar, Bernard Bass (1985), built on Burns' notions of leadership and also corrected a fundamental error in Burns' theory, namely, Burns' assertion that transformational and transactional leadership are at opposite ends of a single continuum of leadership. On the basis of his later research (Bass & Avolio, 1990a, b), Bass found the two approaches to be independent and complementary. Bass asserts that transactional leadership entails an exchange between leader and follower in which the

leader rewards the follower for specific behaviours, and for performance that meets with the leader's wishes, and criticises, sanctions or punishes non-conformity or lack of achievement. Rewards may be tangible, such as financial 'perks' and incentives, or non-tangible, such as prestige. Such exchanges cater to the self-interest of followers (Bass, 1998a). Zaleznik (1993) refers to transactional leaders as managers, and states that they "concentrate on compromise, intrigue, and control. They focus on the process not the substance of the issues. They are often seen as inflexible, detached and manipulative." (p. 13).

Bass also argued that research comparing the effects of transactional and transformational leadership has shown that "generally transformational leadership is more effective and satisfying than transactional leadership alone although every leader does some of each. Context and contingencies are of some importance as a source of variance, but the fundamental phenomena transcend organizations and countries" (Bass, 1998a, p. 1). Bass (e.g., 1997, 1998a,b) cites an extensive range of studies, from almost every continent and a range of sectors, including industrial, military, educational, healthcare, and voluntary agencies, to support his conclusion that the transformational approach to leadership produces superior outcomes than the adoption of transactional leadership alone.

Bass developed his model of transformational leadership based on data from interviews with seventy South African executives, in which he asked them if they had known transformational leaders, as described by Burns. From these data, he and his colleague Bruce Avolio developed an instrument which measures the full range of leadership modes, the 'Multifactor Leadership Questionnaire' (MLQ) (Bass & Avolio, 1990a,b).

This measures the following dimensions of leadership:

- *Idealised influence*: transformational leaders behave in ways that result in them being admired, respected and trusted, such that their followers wish to emulate them. They are extraordinarily capable, persistent, and determined;
- *Inspirational motivation*: transformational leaders behave such that they motivate and inspire those around them by providing meaning, optimism and enthusiasm for a vision of a future state;
- *Intellectual stimulation*: transformational leaders encourage followers to question assumptions, reframe problems, and approach old solutions in new ways, and to be creative and innovative. At times, their followers' ideas may differ from those of the leader, who may solicit or encourage such responses;
- *Individualised consideration*: transformational leaders actively develop the potential of their followers by creating new opportunities for development, coaching, mentoring, and paying attention to each follower's needs and desires. They know their staff well, as a result of listening, communicating, and "walking around encouraging, rather than monitoring their efforts.

The two transactional components comprise:

- *Contingent Reward*, whereby approved follower actions are rewarded; disapproved actions are punished or sanctioned;
- *Management by Exception (active)* and *Management by Exception (passive)*, which are corrective transactional dimensions. The former involves a monitoring of performance, and intervention when judged appropriate; the latter reflects correction only when problems emerge;
- *'Laissez-faire'*: a style of leadership that is, in fact, an abrogation of leadership, since there is an absence of any transaction. This style is deemed to be most ineffective (e.g., Bass, 1998, p. 7).

More recent research by Bass and colleagues, which analysed 3,786 responses to the MLQ in fourteen independent studies, has led to a revision of the model of transformational leadership, in which the first two dimensions are combined into one (Avolio, Bass & Jung, 1999).

Over 20 years of research has been undertaken by psychologists adopting, most commonly, the MLQ to compare the effectiveness of transformational and transactional leadership styles (Carless, 1998). This has provided evidence that the transformational style is generally more effective and satisfying than the transactional style alone (Bass, 1997; 1998), and that followers' commitment is greater. These studies have ranged from studies of the leadership style of secondary school teachers, white collar worker, and supervisors of insurance company employees, to military personnel (Bass 1998). Other studies have shown a negative relationship between a leader's transformational leadership style and staff stress levels (Bass, 1998).

While there are numerous studies which provide evidence of the superiority of the transformational approach over the transactional, Bass (1998) has emphasised that both are crucial for managerial and organisational effectiveness.

The research methodology adopted by Bennis and Nanus (1985) and by Tichy and Devanna (1986) was to interview CEOs or leaders of large corporations, using a relatively unstructured open-ended question-and-answer format. On the basis of asking questions such as, 'What are your strengths and weaknesses?', 'What past events most influenced your leadership approach?' of ninety leaders, Bennis and Nanus identified four common strategies used by leaders in transformational organisations. These were: having a clear vision that was attractive, realistic, and believable; creating a shape for the shared meanings that individuals maintain within the organisation; creating trust, by making their own position clear, and standing by it; using awareness of their own strengths and weaknesses to emphasise strengths, rather than dwell upon their weaknesses.

The TPC (technical design, political allocation, culture value problems) framework (Tichy & Devanna, 1986), which was based on interviews with 12 CEOs, has as its primary emphasis organisational transformation, and as its secondary emphasis individual transformation. In analysing how strategic leaders transform organisations so that they can deal with dramatic and turbulent change, the framework identified five phases: (1) trigger event –



realisation that events call for change, (2) felt need for change, (3) creation of a vision of a desired future state, (4) mobilisation of commitment, (5) institutionalisation of change. These must be accompanied by three individuals-orientated phases: ending of traditional practices; neutral zone; new beginnings.

In order to achieve success, the leader must, (a) have a thorough understanding of technical, political and cultural aspects of the TPC framework, (b) articulate and model new values and norms, and (c) know when to push and when to hold back, and, when pushing, make quick decisions.

A four-stage charismatic model was devised by Conger and Kanungo (Conger, 1988), in which each stage was seen as requiring differing leadership behaviour and skills. The extent to which a leader is viewed as charismatic is determined by the number of such behaviours, their intensity, and their relevance to followers. The stages comprise: (1) detecting deficiencies and opportunities; sensitivity; formulation of a strategic vision, (2) communicating a vision; articulating its appropriateness; motivating followers, (3) building trust, based on expertise, success, self-sacrifice, personal risk-taking and unconventional behaviour, (4) demonstrating how to achieve the vision using empowerment, modelling and unconventional tactics. Leadership behaviour is assessed along six dimensions – vision and articulation, environmental sensitivity, unconventional behaviour, personal risk, sensitivity to member needs, not maintaining the *status quo* (Hunt, 1996). Kouzes and Posner (1998) identified five practices that they regard as “essential to effective leadership: (1) challenge the process, (2) inspire a shared vision, (3) enable others to act, (4) model the way, and (4) encourage the heart.

## **Comment**

Instruments such as that devised by Bass have been shown to measure leadership behaviours among very senior staff that are positively associated with organisational performance, and their face validity has led them to be adopted for use in a wide range of cultural settings. Also, transformational leadership behaviours assessed using the MLQ in particular are significantly positively correlated with attitudes to work.

On the other hand, models of transformational leadership have been criticised for having poorly defined parameters (Northouse, 2004), for treating leadership as a personal predisposition, rather than a behaviour that can be learnt (Bryman, 1992). Furthermore, the methodology adopted in many of the studies has come in for serious criticism on three counts.

Firstly, the data upon which the models devised by Bennis and Nanus, Tichy and Devanna, and Conger were based on self-reports. As the unprecedented torrent of critical comment prompted by Rosener's (1990) article in '*Harvard Business Review*' testifies, information gathered in this way is, at best, aspirational, rather than evidential, and is notoriously unreliable (Hogan & Hogan, 2001). Furthermore, both of these studies and the research

undertaken in the development of Bass' MLQ, were based exclusively on male managers, all of whom (with the exception of the one Black manager interviewed by Bass) were white. The findings were then extrapolated to humanity in general. The second, and equally profound cause for criticism, is that they are models of 'distant' leadership; exclusively models of the behaviour of individuals who occupy very senior positions in organisations. Thirdly, there is very considerable emphasis on the significance of 'charisma'.

### *Dark side of 'charisma'*

The early days of leadership research focused on personality traits and leadership effectiveness, but more recent research has sought to understand whether there are any common traits that seem to be associated with failure, and 'derailment', that is a failure to meet the expectations that follow a promotion, or lack of success in a particular position.

While derailment research was originally undertaken in the 1960s (Bentz, 1967), it has only recently received wide attention, arguably due to the spectacular failure of corporate governance of companies such as Enron, AmCom, and Worldcom in the USA, when corruption in the most senior managers led directly to the collapse of previously high performing companies.

Bentz identified certain psychological characteristics of successful managers, including: persuasiveness, social assurance, ambition, initiation, energy, mental ability, and need for status, power and money. But he then investigated the characteristics of those who failed, and found they also possessed certain characteristics in common. They all lacked certain positive personality characteristics, such as emotional stability and social skills. Seven 'personality deficiencies' were common among failed managers. These deficiencies included:

- the inability to delegate or prioritize,
- being reactive rather than proactive,
- having poor judgment,
- being a slow learner, and
- having an overriding personality defect or character flaw that alienated subordinates, thus preventing them from building a team.

Research on derailment did not continue in the 1970s, but McCall & Lombardo (1983) of the prestigious Centre for Creative Leadership re-opened the topic by proposing that effective leadership not only requires the presence of 'positive' personality characteristics, but also the absence of 'negative' traits. They interviewed 40 senior executives (half of which were successful managers, while the other half were derailed), and found, again, that they possessed some characteristics in common, which were:

- specific performance problems,
- insensitivity to others,
- failure to delegate or build a team, and

- overdependence on a single advocate or mentor.

Other researchers picked up the theme, including another researcher at CCL, Morrison (1987). Morrison noted that MacCall and Lombardo had only included men in their sample, so she extended her research to collect data on female managers who had derailed. Again, she found some themes, which were:

- The inability to adapt – not being able to adjust to changes such as new job expectations, a new boss, culture change, etc. Also included were problems facing reality and accepting criticism.
- Performance problems – examples include being promoted into positions that they could not handle successfully, not meeting the expectations of superiors, reaching for quick answers, causing a loss of money for the company due to mistakes, or maintaining the business without any growth.
- Being overly ambitious – wanting too much in terms of requesting perks, advancements, or a bigger salary. Self interest was seen as a priority over team goals.
- Other factors include - inability to lead subordinates or to be strategic, presenting a poor image, and having poor relationships in the workplace.

Although Morrison did not draw specific conclusions as to the differences between derailment factors found for men and women, Torregiante, Kelley & Michelle (2005) scrutinised the two studies and found some similarities between genders (e.g., performance problems), as well as some differences (e.g., men are insensitive to others; women are overly ambitious).

They also note that Lombardo and McCauley (1988) conducted a factor analysis on the questionnaire from the original study, using performance ratings from the managers' superiors. The resulting analysis grouped the original categories into six scales: - problems with interpersonal relationships; difficulty in moulding a staff; difficulty in making strategic transitions; lack of follow-through; overdependence; and strategic differences with management.

Finally, Torregiante *et al.* (2005), noted that Leslie and Van Velsor (1996) repeated and expanded the original study almost a decade later, to determine whether the situation had changed, and whether there would be differences emerging between US and European managers.

They found that across both samples, a total of ten 'personality flaws' were found to contribute to leadership derailment. These flaws included:

- poor working relations
- the inability to develop or adapt
- inability to build and lead a team
- being promoted into positions that s/he is not prepared to handle successfully
- being too ambitious
- poor performance

- authoritarian leadership style
- too narrow functional orientation
- conflict with upper management, and
- organisational isolation.

They concluded:

“Thus, most factors found previously were also found in Leslie and Van Velsor’s study, with a few exceptions (e.g., overdependence on a single advocate, presenting a poor image, making strategic decisions, and lack of follow-through). In addition, several new factors emerged (e.g., authoritarian leadership style, not being prepared for promotion, too narrow functional orientation, conflict with management, and organizational isolation). In comparing the samples of US and European derailed managers, the top two factors for both groups were poor working relations and the inability to develop or adapt. In other words, over 50% of cases across both samples mentioned these two factors as the leading cause of derailment. However, one key difference was found. One derailment factor, organizational isolation, was found only in the European sample. Managers with this flaw were described as people who placed boundaries around their unit, department, or function.

Finally, in comparing the derailment themes over time and across studies at the Centre for Creative Leadership, four dominant derailment themes persisted:

- Problems with interpersonal relationships
- Failure to meet business objectives
- Inability to build and lead a team
- Inability to change or adapt during a transition.

These themes can be viewed as reflecting not only the lack of certain ‘positive’ qualities, but also the presence of ‘negative’ personality traits. For example, problems with interpersonal relationships might be due to excessive emotion, selfishness, authoritarian leadership style, or extreme sensitivity to criticism. Compared to a weaker manager who lacks certain positive qualities, a manager who possesses specific negative personality traits may have more opportunity to cause harm in a leadership role. Such a manager might cause substantially more damage in the long run, possibly alienating subordinates, losing the support of the team, slowing productivity, and ultimately leading to career derailment for the manager and adverse consequences for the organization (Hogan, Raskin, & Fazzini, 1990).

Flaws in the personal characteristics of those occupying leadership roles, has again come to the fore, and the phenomenon is referred to as ‘the dark side of charisma’ (Hogan, Raskin, & Fazzini, 1990).

Hogan has been at the forefront of research into ‘the dark side’, and has extolled organisations to not only focus on identifying the presence of certain

positive characteristics, but equally importantly, to ensure the absence of 'dark side' traits, particularly those that alienate other colleagues, most importantly, subordinates, and the inability to build and support a team (Hogan, Curphy, & Hogan, 1994).

It is not, however, always easy to identify individuals who reflect the 'dark side of charisma', since certain individuals who appear charismatic, and highly attractive, might hide more lethal characteristics below the surface. Indeed their very attractiveness and social skills increases the chances of them being supported for promotion by colleagues, and the discovery of their 'dark side' might come too late to save individuals and organisations from the damage and destruction they have wrought along the way.

Hogan's concern to identify such negative traits, has led to the creation of the Hogan Personality Inventory (HPI; Hogan & Hogan, 1986), which is being used increasingly in organisations. Amongst the three types of manager profiles identified by the HPI, is the 'Narcissists'. Narcissists possess a talent for self-presentation, and consequently may create favourable impressions, and will self-promote into leadership roles looking for recognition. Their 'dark side' flaws include:

- feelings of entitlement and exemption from social demands
- controlling and manipulative of others
- intolerance to criticism, and
- exploit others for self-advancement and recognition.

Other writers have pointed to the potential dark side of charisma, including Conger (1990), Howell (1988), and Yukl (1999). They all recognise that there are two sides to charisma – the positive, which acts to energise and excite others, and create a sense of 'mission' and purpose for one's efforts, and the dark side. Yukl (1999) argued that charismatic leadership research has dismissed the dark side, led by Burns' (1978) interpretations of charisma as a heroic form of leadership that is absent of conflict. But he points out that charismatic leaders also use manipulative behaviours, such as "exaggerating positive achievements and taking unwarranted credit for achievements," "covering up mistakes and failures," "blaming others for mistakes," and "limiting communication of criticism and dissent" (1999, p.296).

### *Leadership & humility*

While some writers have focused on their concerns with the dark side of charisma, there has also been an increasing interest in the notion of 'humility' as a characteristic of leadership. This movement has been partly fuelled by the success of a book entitled '*Good to Great*' published in 2001, which is based on the findings from a substantial study by US writer Jim Collins. Collins (2001) set out to investigate whether there were any characteristics in common among Chief Executives of organizations quoted on the US Stock Exchange, which moved their organizations from solidly 'good' performance, to 'outstanding performance, and maintained their superior market position for at least 15 years.

Based on the observations in his sample of over 1,400 organisations, and controlling for a wide range of variables such as specific economic factors affecting the performance of certain industries, organisational size, etc, Collins identified eleven such chief executives. Of the characteristics in common, the two most evident, were their unflinching belief that their company would be the best in its field, and the second was their deep personal humility. In fact, they appeared unassuming, and not very charismatic. Interestingly, Collins adds that of the companies that he observed as being on a downward spiral, for at least two-thirds of them, their failure could be attributed to the presence of a CEO with 'a gargantuan ego', who began a major re-structuring campaign shortly after taking office, and thereafter caused chaos.

Among other leadership academics promoting an anti-heroic leadership model, are Badaracco (2002) with his concept of 'quietly leading' and his promotion of 'moral leadership', and Canadian scholar Henry Mintzberg (1999) with his thoughts on 'managing quietly'.

### *Distant leadership*

Gronn (1999), in expressing concerns about what he regards as a current obsession with transformational leadership, asserted that the notion of 'heroic' leadership has long been discredited and is virtually defunct. However, Bryman (1996) pointed out that the 'new paradigm' leadership studies were based on samples that differ significantly from those of the early Ohio State University researchers, and by Fiedler, which focused on individuals at supervisor/first level, and middle levels managers.

In contrast, Bryant noted that studies, such as those of Peters and Waterman (1982), Conger (1989), and Tichy and Devanna (1986), were based on the observation of very senior managers in large US corporations. Conger's initial research was based on a study of 19 CEOs, while Tichy and Devanna collected data from 12 sets of interview data.

A further source of difference from the Ohio studies, which used standardised questionnaires, was the use of case studies of senior executives of world-leading companies. Thus, apart from the nature of the sample, there have been differences in the method of data collection used.

The issue of choice of sample has also been raised by Alimo-Metcalfe & Alban-Metcalfe (2001), who pointed out that the charismatic, visionary, and transformational models derived from the US, were based on observations of 'distant leaders', such as chief executives, religious leaders, and politicians, rather than 'close' or 'nearby leaders', such as individuals' immediate bosses. Two issues are relevant here.

Firstly, Shamir (1995) has shown that 'social distance' affects notions of leadership. When a sample of 320 Israeli students was asked to describe the characteristics of a 'close' and a 'distant' leader whom they regarded as charismatic, similarities and significant differences were detected. 'Distant'

charismatic leaders were characterised as having rhetorical skills, an ideological orientation and sense of mission, as being persistent and consistent, and as not conforming to social pressures – descriptions which are typically reflected in the ‘new paradigm’ models. In contrast, ‘close’ charismatic leaders were more frequently characterised as sociable, open and considerate of others, with a sense of humour and high level of expertise in their field, as being highly dynamic and active, having an impressive physical appearance and perceived as intelligent, as setting high performance standards for themselves and their followers, and as original or unconventional in their behaviour. In the main these characteristics are not emphasised in ‘new paradigm’ models.

### *Generalisability*

Despite the fact that instruments that measure transformational leadership have been validated in various countries and cultures (e.g., Bass, 1997), the question can be asked as to whether the items which they comprise can be presumed to reflect the perceptions of leadership in those diverse cultures (Alimo-Metcalfe & Alban-Metcalfe, 2001). Research by Den Hartog, House and associates (1999) indicated that, while certain aspects of charismatic/transformational leadership generalise over a wide range of cultures, others do not (Alban-Metcalfe & Alimo-Metcalfe, 2000a, b).

Although there is undoubted respect for Bass’s model of leadership, and his contributions to the literature, his work has not been without its critics. Hunt (1996) cites four criticisms: (1) that the MLQ was developed before there had been substantial data gathered on the nature of transformational leadership, from methodologies such as interviews and observations; (2) that the MLQ includes both descriptions of leader behaviour and outcomes of behaviours; (3) that the Individualised consideration scale contains items reminiscent of those included in previous leadership scales developed some decades earlier, with the descriptions of transactional leadership implying an ineffective leader; (4) that the model gives insufficient attention to the two-way aspects of leader-follower relations. Bass and Avolio (1993) have addressed these criticisms in a paper devoted to the debate.

A further observation about the methodology adopted in the major models of transformational leadership - and in earlier models - is that they have been developed from studying White males, with the findings extrapolated to people in general. The MLQ, for example, was based on interview data from 70 South African executives – sixty-nine of whom were white, and all of whom were men – augmented by descriptions of transformational and transactional leadership in the literature. The pilot instrument developed from the descriptions was initially tested on a sample of 172 US Army Colonels, who were asked to provide views of their superior officer. The sample comprised 98% males.

At the same time, it is fair to say that Bass’s model of leadership and the MLQ have made a very substantial contribution to, and furthered understanding of,

the nature of transformational and transactional leadership, and to their relevance to organisations.

### *Leadership as a social process*

Secondly, as Alimo-Metcalfe & Alban-Metcalfe (2001) pointed out, one of the important aspects of new paradigm models is an emphasis on the importance of followers' attitudes and feelings towards the leader. These, however, appear to have been ignored when gathering data on leader characteristics. Since leadership is ultimately a social process (e.g., Bass, 1998; Conger, 1998), it may be argued that followers' perceptions of leadership are a better arbiter of what constitutes leadership in a boss, rather than researchers' observations of distant leaders.

### **Stage 5: Distributed and Engaging Leadership**

This stage is characterised by: - an end to what has been described as 'the study of white males by white male', and extrapolation to humanity in general; a move away from an exclusive focus on CEOs; the distinction being drawn between the characteristics of 'distant' as opposed to 'nearby' leaders; the development of the concept of 'distributed' leadership; recognition of the difference between leader development and leadership development; and, in short, a transition from an 'heroic' to a 'post-heroic' era, with recognition of the human and financial benefits of a more inclusive and 'engaging' style of leadership.

One of these least known areas of leadership research, is the study of leadership and social distance. A core, if not defining, component of US models of 'the new leadership' paradigm (Bryman, 1996), is that of charisma. It forms the first dimension of Bass's model, and is central to that of Conger and Kanungo (1987). 'Charisma' is an attribution that followers make of certain individuals from observations of their behaviours (Willner, 1984), and is, arguably, influenced by the social distance between leader and follower. It has been a subject of interest to psychologists in the leadership field from at least the 1970s, with Katz and Kahn (1978) maintaining that social distance is an essential prerequisite of charismatic leadership. This is because immediate bosses/supervisors are constantly under the scrutiny of their staff and cannot escape being viewed as "very human and very fallible and their subordinates cannot build an aura of magic about the [since] ... Day to day intimacy destroys illusions" (Katz & Kahn, 1978, p. 546, cited in Yagil 1998, p.162).

Other writers, however, including Bass (1985) assert that charisma is a phenomenon of interpersonal relationships, and can thus be attributed to a supervisor with whom staff work closely on a regular basis, and can be evident in managers at any level in the organisation.

Yagil (1998) in her study of the attributions of charisma of Israeli soldiers to their close and distant leaders (i.e., platoon and battalion commanders



respectively), found that the *proximity* of distance between leader and follower was in fact an advantage. She stated:

“First, a leader’s close acquaintance with followers allows him or her to deliver sensitive and individually tailored confidence-building communications, which are probably more effective than messages addressed to a group as a whole. A second advantage emanates from the perception of the leader as a realistic, approachable figure, thus enabling him or her to influence followers through personal modelling. Furthermore, the perception of close leaders as human and fallible does not necessarily reduce their influence; it might, in fact, actually heighten the followers’ attraction to them (Aronson, Willerman & Floyd, 1966) and further stimulate identification and emulation” (Yagil, *op. cit.* p.172).

Israeli psychologist Shamir (1995) has argued that it is important to distinguish between the study of *distant* and *close* leaders when investigating the characteristics of charismatic leaders. He maintains that notions of charismatic leaders have changed historically, from earlier notions of somewhat “unrealistic and idealized perceptions of the leader”, to a newer conception of charisma “in which this ingredient is absent, or at least much less emphasized” (*op. cit.* p. 23). Shamir also pointed out that the characteristics of leaders emerging from studying distant charismatic leaders have been inappropriately applied in studies of nearby charismatic leaders.

In order to examine whether social distance affects perceptions of charismatic leadership, Shamir (1995) undertook an exploratory investigation of the characteristics associated with close and distant charismatic leaders, in which a sample of 320 Israeli students were asked to describe the characteristics of a close, and a distant charismatic leader of their choice, with respect to three aspects of the leader: - the characteristics of each leader, the behaviours of each leader, and the leader’s impact on the student and others. The descriptions were content analysed, adopting the behavioural and effect categories provided by the major leadership theories of House (1977), Conger & Kanungo (1987), Shamir, House & Arthur (1993), and from the charismatic dimension of Bass’s (1985) model of transformational leadership. While some similarities emerged in the lists of leader characteristics, behaviours, and effects, of close and distant leaders, several significant differences were also found. Thus,

“Distant charismatic leaders were more frequently characterized as having rhetorical skills, having an ideological orientation and a sense of mission, being persistent and consistent with respect to their mission, being courageous, and having social courage in the sense of expressing their opinions without fearing criticism or conforming to social pressures.

“Close charismatic leaders were more frequently characterized as being sociable, open and considerate of others, having a sense of humor, having a high level of expertise in their field, being highly

dynamic and active, having an impressive physical appearance, being intelligent or wise, setting high performance standards for themselves and their followers, and being original or unconventional in their behavior” (Shamir, *op. cit.* p. 31).

The behaviours which Yagil found as importantly related to attributes of charisma among close leaders were not interpersonal qualities, as found by Shamir, but ‘extraordinary’ qualities. While Yagil was at pains to point out that this does not imply that close leaders are perceived as lacking interpersonal qualities, she pointed that “such qualities are not perceived as an important component of charisma” (*ibid.* ), and that it is worth noticing that the qualities described as ‘extraordinary’ included ‘brilliant’ and ‘a hero’. Yagil herself noted the positive nature of these characteristics, but we may also ask whether these are the sorts of attributes that would be emerge from studies in non-military organisations.

In terms of considering the value of such research in illuminating the nature of transformational leadership in organisations, it is important to note a few further points about these studies of close and distant leadership.

The first is that Shamir’s study was based on a sample of Israeli students, who were asked to consider the qualities of a charismatic ‘distant’ and ‘close’ leader of their choice. No definition of ‘charismatic’ was provided, deliberately, since this might have influenced the very notions they were seeking to investigate. Secondly, of the distant leaders selected by the students, the majority (81%) were political leaders, and of the majority of close leaders chosen, “28% were teachers and educational leaders at various levels from elementary school to the university, 26% were military leaders ... 24% were informal leaders and peers such as classmates and friends” (Shamir, *op. cit.* p. 195). Whether similar findings would have emerged in commercial, or even public sector organisations, other than military ones, has yet to be tested.

Another question for those interested in leadership in non-military organisations, and organisations other than those in the US, is whether ‘charisma’ is the appropriate starting point for understanding the nature of transformational leadership. Certainly, it does suggest a very exclusive notion of leadership, with single individuals seen as occupying the role and functions being a leader, rather than any sense in which the way in which organisations are led is through cooperation between individuals at the same or different levels.

### *Gender and Leadership*

The historical study of what is the nature of leadership has represented the history of men’s approaches to it. Several writers have documented the history of leadership research from the perspective of gender and concluded that there has been a distinct male gender bias with respect to the construction of leadership (e.g., Calas & Smircich, 1996; Jacobson & Jacques, 1990; Kark, 2004; Schein, 1994), and with respect to the

interpretation of findings which have compared men's and women's approaches (e.g. Jacobson & Jacques, 1990). Prior to the 1970s there was little, if any, interest in the question of whether there are gender differences, since only men were studied. Following equal opportunities legislation in the US and the UK in the early 1970s, women were entering previously male occupations, such as management, and gender differences in leadership styles were investigated. Few differences were found (e.g., Powell, 1993), and when found, they were relatively minor, but they suggested that women were likely to be more participative and democratic in decision-making (e.g., Eagly, 1991), and more team-orientated (e.g., Ferrario, 1990). However, feminist writers, such as Gilligan (1982), made the perceptive point that the differences were drawn as a result of women being compared to the male norm, as opposed to an 'emic' study of differences (Berry, 1969; Pike, 1967) in which each gender is viewed in its own right.

It was only in the 1990s that major significant differences with respect to gender and leadership style began to emerge. Adopting the MLQ, a US researcher, Judy Rosener (1990), published the findings from a survey of female and male executives' descriptions of their leadership approach. It revealed significant differences with respect to their stated leadership styles, with women scoring higher on the preference for transformational behaviours (apart from Intellectual Stimulation, which showed no significant differences). A possible reason for the lack of gender differences in previous studies, may have been due to the fact that leadership instruments designed prior to the MLQ had only measured transactional aspects of leadership (Alimo-Metcalfe, 1994; Bass, Avolio & Atwater, 1996).

Rosener's research attracted a great deal of interest, and criticism (*Harvard Business Review*, 1991, letters section). The main criticism was that the data were of dubious validity, since they were based solely on self-report. Whilst this criticism is indeed legitimate, the question must be asked as to what the data may represent. If not *actual* differences in leadership style, then presumably, they must represent aspirational differences, or 'constructs' of what is regarded as leadership. In relation to the latter, two independent UK studies which investigated the constructs of leadership held by senior female and male managers in two major public sector organisations (Alimo-Metcalfe, 1995; Sparrow & Rigg, 1993), obtained data which supported Rosener's findings, with women in general, identifying transformational components, and men in general, identifying transactional ones.

Alimo-Metcalfe (1994) has argued that the implications of these findings for organisations' managerial selection, assessment, and development processes, are considerable, with respect to the sample from whom the assessment criteria are elicited, the content and method of the assessment process, and the judgement of assessors.

As was stated above, Rosener's study was criticised for drawing conclusions as to gender differences in leadership style from self-report data, however, there are now several studies that have looked at gender and leadership style as rated anonymously by co-workers of managers as part of 360-degree

feedback. Such studies have consistently revealed that women are rated as significantly more transformational, in general, than men (e.g., Bass & Avolio, 1994; Bass, Avolio & Atwater, 1996; Druskat, 1994).

More recently, Alimo-Metcalfe (2007) found evidence that female managers and professionals are likely to be rated as more transformational than their male counterparts, even when rated by male direct reports.

### *Leadership and cultural differences*

Perhaps not surprisingly, in light of the attitude to difference evidenced in the previous section, only a few studies have investigated leadership among diverse groups of individuals, with reference to ethnicity or culture, faith tradition, disability, sexual orientation, etc. However, a small number of recent studies are worthy of note.

Recent attention has focused on the extent to which notions of leadership (both transformational and transactional) generalise from one culture to another. Here, both 'emic' or idiographic, and 'etic' or nomothetic approaches have provided evidence of leadership behaviours that are cross-cultural, and those that are culturally-specific (Berry, 1969; Den Hartog, House, Hanges, Ruiz-Quintanilla, Dorfman & Associates, 1999; Pike, 1967). Thus, Dorfman and colleagues examined the generalisability of six leadership behaviours and processes across five Pacific Rim countries (Dorfman, Howell, Hinino, Lee, Tate and Bautista, 1997). They found evidence of 'cultural universality' for two transformational behaviours, 'supportive' and 'charismatic', and one transactional behaviour, 'contingent reward'. However, a further transformational behaviour, 'participative', and two transactional behaviours, 'directive' and 'contingent punishment', were found to be culture-specific.

Rao, Hashimoto and Rao studied the leadership behaviour of Japanese managers, as measured by the 'Profile of Organization Influence – POIS/M' (Rao, Hashimoto & Rao, 1997). What they found was that, whereas three of the seven strategies identified by *POIS/M* – 'assertiveness', 'sanctions' and 'appeals to higher authority' – are used by Japanese managers, the behaviours that constitute the other strategies were interpreted differently. Moreover, the Japanese used some culturally specific tactics and strategies.

An extensive, international investigation of the generalisability of concepts of leadership among a total of 62 cultures led to the identification of twenty-one lower order and six higher order concepts (Den Hartog, *et al.*, 1999; House, Hanges, Ruiz-Quintanilla, Dorfman, Javidan, Dickson, Gupta & Associates, 1999). Using a combination of emic and etic approaches, evidence was presented to support their hypothesis that certain, specific aspects of charismatic/transformational leadership behaviour are common to individuals from a wide range of cultural backgrounds.

### *Ethnicity and leadership*

In an investigation of perceptions of effective leadership among male and female 'black' and 'white' managers working in a bank in South Africa was undertaken by Booyesen (2000). Different perceptions of leadership of 'black' versus 'white' staff are summarised as follows: -

White managers	Black managers
<ul style="list-style-type: none"><li>• competition &amp; work-orientation</li><li>• free enterprise</li><li>• liberal democracy</li><li>• individual self-sufficiency</li><li>• self-fulfilment</li><li>• exclusivity</li><li>• planning and methodology</li></ul>	<ul style="list-style-type: none"><li>• collaboration</li><li>• consensus and group agreement</li><li>• collective solidarity</li><li>• concern for people</li><li>• inclusivity</li><li>• respect &amp; dignity</li></ul>

While it is not suggested that these findings present a picture that applies to black managers in general, any more than it applies to white managers in general, they do serve to point to differing sets of underlying values and assumptions.

Given the fact that the vast majority of senior and top positions in organisations, including those in the UK (Equal Opportunities Commission, 2006), are dominated by white males (e.g., Davidson & Burke, 2004), and that ethnicity and gender appear to influence notions of leadership, there is considerable risk of bias pervading assessment processes when it comes to the identification of talent for leadership, and the evaluation of leadership effectiveness in organisations.

From research conducted in the UK public sector, we have evidence that amount and quality of feedback given to managers from a black or minority background has deleterious effects on their career progression (Alban-Metcalfe, 2004a). Specifically, lack of support from line manager for development, lack of good quality feedback, lack of training and development, being excluded from decision-making situations, out-group status, and poor quality appraisals, all contributed to their disadvantage.

And in a separate study comparing the 360-feedback ratings of black and white male and female managers in local government (Alban-Metcalfe, 2004b), that black managers, and white females are rated lower in their effectiveness by their boss, than are white males, but rated higher by their peers and direct reports. This latter finding is particularly important, since ratings by peers and direct reports have been found to be more valid than those of bosses (Fletcher & Baldry, 1999; McEvoy & Beatty, 1989).

On the basis of empirical research, Warner & Grint (2006) developed a model of American Indian leadership, which, they emphasise, is not *the* model of

such leadership since, as they point out there are both differences with US styles of leadership, and differences between different American Indian groups. They noted (1) that American Indian models are principally concerned with techniques that involve persuasion, whereas western models are essentially positional, and (2) that the former are “much more concerned with how different forms of leadership – individual or collective – in different circumstances can serve the community rather than enhance the reward and reputation of their individual embodiment” (p.240).

### *Age and Leadership*

Parry and Fischer (2004) reported older managers as engaged in more leadership processes than younger managers. They suggested that this might imply that they have more managerial experience, thus allowing them to initiate more leadership processes, and/or that they are more aware of such processes within their work unit, or view their work unit more favourably because they are in charge of it.

### **A UK Study of Transformational or ‘Engaging’ Leadership**

Over the last seventy plus years, US researchers have provided an invaluable source of information about the nature of leadership, and they still dominate the landscape. However, other researchers, both in the US and elsewhere, have started to point out the absence of consideration for the influence of context in modern studies of transformational leadership (e.g., Yukl, 1999), not least of which is the influence of different cultures across the world. With the increased moved to global-thinking in organisational effectiveness, there must be a need for studies to be undertaken outside the US (e.g., Adler, 1983a,b; Erez,1990; Hunt & Peterson, 1997; Smith & Bond, 1993; Triandis, 1990, 1993). Such research must take full account of cultural and other contextual factors, and not simply involve testing a model that has been developed elsewhere, as would appear to be the case in the ‘Globe Study’ (Den Hartog *et al.*, 1999).

For such research to add value to our understanding of the nature of leadership, it is essential not to start with an existing notion of leadership, such as presuming it to relate to a defining component, such as charisma. Thus, it is most appropriate to start with a qualitative methodology, using a ‘grounded theory’ approach, rather than merely testing the validity of an existing instrument. This is also particularly important since leadership is a social influence process (Parry, 1998), and it is best judged by the observations of followers (e.g., Bass, 1990; Rost, 1993). It is also important to recognise, as noted above, that all major models of leadership have been based on studies involving samples of individuals which comprised predominantly, if not solely, of ‘white’ men.

The national study of the nature of leadership undertaken by Alimo-Metcalfe & Alban-Metcalfe (2001) addressed these issues by collecting empirical data from a sample that was representative in respect of gender, ethnicity and level in the organisation. The first stage of this study was undertaken in two major

public sector organisations (NHS and local government). It involved interviewing one hundred and sixty female and male managers, at Chief Executive to middle level positions in various organisations in these two public sectors, employing the Repertory Grid technique of eliciting constructs (Kelly, 1955). From the two thousand plus constructs of leadership elicited, groups of constructs were identified and items representing the groups were devised, using Facet Theory (Donald, 1995). A pilot instrument was developed and distributed within over 800 organisations to a random stratified sample of male and female managers at various levels within each organisation, who were asked to consider their current, or a previous boss, and to anonymously rate the extent to which they agreed with the items which described behaviours relating to leadership.

Factor analysis of the responses from each of the two major public sector organisations revealed nine and six factors respectively (Alimo-Metcalfe, 2001; 2005a). There was a great deal in common in the results from these two public sectors. The model of leadership which emerged reflected, in part, descriptions of transformational leadership previously described in the US literature, but there were some important differences between the US and the UK findings.

The first most important difference was that 'charisma', which forms the major component in several US models (Bass, 1990, 1998; Conger, 1989; Conger & Kanungo, 1988, 1998; House, 1977; Shamir, House & Arthur, 1993), is far less conspicuous as a defining leadership quality in the UK model. The major component of the UK model is 'Genuine concern for others' well-being and development'. This is similar in some ways to Bass' fourth, and by implication, least important transformational dimension which he named 'Individualised consideration', and far more a reflection of the 'leader as servant' model proposed by Greenleaf (1970, 1996).

Thereafter, emphasis on the UK model is on connectedness with stakeholders, internal and external to the organisation, the development of leadership in others by empowerment and encouraging the questioning of approaches to one's job and the way in which service is delivered. While these latter characteristics are reflected in the Bass model, there is still a 'heroic' core to his and other US models, as noted by Yukl (1999). Furthermore, visioning in the UK model is defined by behaviours of engaging others in the process, as opposed to a single individual's actions. What emerges is a more complex and more inclusive model of leadership.

It is not clear to what extent the differences in the UK model are attributable to the methodology employed, which was initially qualitative, or to the involvement of a significant proportion of females as well as males in the design of the leadership questionnaire piloted, and in the sample on whom the final analyses were based, or to the fact that this first study was conducted in the public sector, or to a combination of these and other factors.

It is unlikely that the nature of the sample has a significant influence. This is because the findings have been replicated in three other empirical studies, in

which the same grounded theory methodology was used. Two of the studies were conducted by Alimo-Metcalfe and Alban-Metcalfe among a representative sample of the staff in three FTSE100 companies and among 192 Governor-grade and Principal and Senior Officer staff in HM Prison Service (Alban-Metcalfe & Alimo-Metcalfe, 2007). The third study, which was additionally representative with respect to declared sexual-orientation, was undertaken among 150 police officers and staff at all levels, in England and Wales (Dobby, Anscombe & Tuffin, 2004). The content, face, construct, convergent and discriminant validity of the instruments that emerged from these studies has been established in a number of different contexts (Alban-Metcalfe, 2000a, b; Alimo-Metcalfe, Alban-Metcalfe & Briggs, 2003; Miller, 2006; Kelly, Robertson & Gill, 2006).

The implications of this first study for UK organisations are widely-ranging. The style of leadership that emerges is one that is best described as 'engaging' leadership, a style of leadership that is wholly consonant with that seen by North American writers such as Greenleaf (1970), who coined the term 'Servant Leadership'. Servant leadership is primarily about leadership as a process of supporting others to become better leaders and better people as a result of 'working in the background'. Badaracco's 'quietly leading', Senge's thoughts on leadership as described in his book *'The fifth Dimension'*, the ideas on leadership expressed by Bolman and Deal (2003) in their book *'Reframing Organizations'*, and Mintzberg's (1998) notions of 'quietly managing', are all in the same vein. However, while proposing or supporting the notion of engaging leadership, none of these writers has undertaken a research project such as that of Alimo-Metcalfe and Alban-Metcalfe (2001), to identify the exact nature of the behaviours that comprise 'engaging leadership' nor developed a reliable and valid instrument to measure it.

### **Definition of Engaging Leadership**

The product of engaging leadership has been defined as "a measure of the extent to which employees put discretionary effort into their work" (Towers Perrin, 2005). Engaging leadership is a style of leadership that shows itself in respect for others and concern for their development and well being, in the ability to unite different groups of stakeholders in developing a joint vision, in supporting a developmental culture, and in delegation of a kind that empowers and develops individuals' potential, coupled with the encouragement of questioning and of thinking which is constructively critical as well as strategic.

Engaging leadership is based on integrity, openness and transparency, and genuinely valuing of others, along with being able to resolve complex problems and to be decisive. It is essentially open-ended in nature, enabling organisations not only to cope with change, but also to be proactive in meeting the challenge of change. At all times transformational behaviour is guided by ethical principles.

The relationship between being engaging and being transformational may best be summarised by suggesting that an engaging style of leadership is



effective in transforming organisations. However, as the distinction drawn by Kotter (1990) between management and leadership suggests, a purely managerial style of leadership is not enough; it must be accompanied by an engaging or post-heroic transformational leadership style if successful organisational performance is to be achieved.

It is the responsibility of organisations to increase and sustain the motivation, job satisfaction, and job and organisational commitment of its staff. This is not just a moral imperative, but is because staff attitudes have consistently been found to affect performance and turnover (e.g., Patterson, Warr & West, 2004; Xenikou & Simosi, 2005). It is also known that work-related stress can have a dysfunctional impact on performance. We also know that individuals' motivation, job satisfaction, and commitment are influenced by the nature of the relationship between individual staff and their line manager, and that the core element of this process is the leadership approach of the line manager.

Key to understanding how leadership affects motivation and performance at an individual, team, and organisational level, is the concept of 'engagement', which is fast becoming the 'holy grail' of organisational success. The rewards for high engagement are considerable with several recent studies having shown indisputable links between engagement and various measurements of financial success in the private sector. Thus, for example, a US survey of 24 publicly listed traded companies with a total of over 250,000 employees conducted over the last 5 years, found that the stock prices of the 11 highest morale companies increased an average of 19.4%, whilst those of other companies in the same industries increased by an average of only 8% – a margin of 240% (Sirota Survey Intelligence, 2006).

In addition, a Watson Wyatt study (2005) asserts that a company with highly engaged employees typically achieves a financial performance four times greater than a company with poor employee attitudes. High job and organisation commitment, which are affected significantly by levels of engagement, also leads to reduced absenteeism and turnover. In large public sector organisations, the costs of absenteeism and of training new staff are among the highest financial burdens. A recent item in the *Health Service Journal*, relates the effect of engagement to financial savings in an NHS Trust. The Leeds Mental Health NHS Trust made savings of over £1.8 million in the short-term, with the promise of a further equivalent saving, when the Trust focused on increasing involvement of staff in achieving shared organisational targets, and worked towards transforming a culture of blame into one of learning.

The question is: How can an organisation increase the engagement of its employees? The answer, not surprisingly, lies in the relationship between each individual member of staff and their line manager. In other words, it is the style of leadership of a manager towards their staff which is the essential ingredient in engaging employees. The manager's leadership style also impacts significantly on the culture of the team, and the quality of support offered amongst the team's members.

## Leadership Competencies or Skills

Kotter (1990) proposed a distinction between what individuals do when they are performing managerial activities, and what they do in a leadership role. These can be summarised under the four main activities, shown in Table 5.1.

**Table 5.1 – Kotter’s distinction between management and leadership** <sup>2</sup>

<b>Activity</b>	<b>Leadership</b>	<b>Management</b>
<b><i>Agenda creation</i></b>	<b><i>Establishing direction:</i></b> Developing future vision. Articulating the vision in a way to inspire others.	<b><i>Planning-budgeting:</i></b> Developing details strategic plans. Allocating resources.
<b><i>Human resource development for achievement</i></b>	<b><i>Aligning people:</i></b> Enthusiating others to join in achieving the vision. Creating teams that understand & are engaged in developing the vision and means to achieve it.	<b><i>Organising/staffing:</i></b> Developing planning and staffing structures, aims & objectives. Providing policies and procedures for guidance, and monitoring systems.
<b><i>Execution</i></b>	<b><i>Motivating/inspiring:</i></b> Energising staff to overcome barriers to change by inspiring, maintaining positive expectations, valuing and developing.	<b><i>Controlling/problem-solving:</i></b> Detailed monitoring of results. Identifying deviations, organising corrections.
<b><i>Outcomes</i></b>	<b><i>Tends to produce:</i></b> Change, often dramatic. Potential for effective change.	<b><i>Tends to produce:</i></b> Order/predictability, efficiency. Results expected by stakeholders.

An alternative way of expressing the distinction between leadership and management – and one that we would suggest is more appropriate – is to think in terms of ‘managerial/leadership competencies’ as distinct from ‘leadership style’, while noting that neither is superior to the other. Indeed, quite the reverse is true; *both* are required, since they are *complementary* to one another.

<sup>2</sup> Based on Kotter (1990)

## What about competencies?

The use of managerial/leadership competency frameworks in the UK, as in the US, has become almost ubiquitous. Bolden, Gosling, Marturano and Dennison (2003), for example, reviewed twenty-nine such frameworks, which were being used in private sector organisations (including Lufthansa, Shell, and BAE Systems), in public sector organisations (including Senior Civil Service, NHS Leadership Qualities Framework, National College for School Leadership), and generically (including Investors in People, Council for Excellence in Management and Leadership). According to the American Management Association, a job competency may be defined as “an underlying characteristic of an individual that is causally related to effective or superior performance in a job” (Boyatzis, 1982, 21). Such a definition is not, however, particularly helpful since it fails to distinguish between an individual’s personal characteristics or qualities (cognitive ability, aptitudes, personality, attitudes toward self and others, motivation), and their behaviours (what they actually do). This is a matter to which we shall return.

The use of ‘competencies’ (sometimes referred to as ‘skills’) has, however, been the subject of recent criticism, both in the UK (e.g., Bolden & Gosling, 2006) and the US (e.g., Hollenbeck, McCall & Silzer, 2006). Thus, on the basis of a review of the literature, Bolden and Gosling pointed out, (1) that the competency approach has been criticised for being overly reductionist, fragmenting the role of the manager, rather than seeing it as an integrated whole (Ecclestone, 1997; Grugulis, 1998; Lester, 1994); (2) that competencies are frequently overly universalistic or generic, assuming that they are the same, no matter the nature of the situation, individual or task (Grugulis, 2000; Loan-Clarke, 1996; Swailes & Roodhouse, 2003); (3) that competencies focus on past or current performance, rather than future requirements, thereby reinforcing rather than challenging traditional ways of thinking (Cullen, 1992; Lester, 1994); (4) that competencies tend to focus on measurable behaviours and outcomes to the exclusion of more subtle qualities, interactions and situational factors (Bell, Taylor & Thorpe, 2002); and (5) that what results is a rather limited and mechanistic approach to education (Brundrett, 2000).

In spite of these criticisms, as Bolden and Gosling point out, there has been an expansion in the use of competencies to incorporate ‘leadership’ as well as ‘management’. They went on to comment that,

“This expansion of the concept of competencies raises further concerns because of its tendency to disguise and embed rather than expose and challenge certain assumptions about the nature and work of leadership.” (2006, p.150)

Buckingham (2001) argued that, however well-intentioned, the competency approach is based on three flawed assumptions. These are: (1) that individuals who excel in the same role display the same behaviours; (2) that such behaviours can be learned; and (3) that improving one’s ‘weaknesses’ necessarily leads to success. Certainly, there is evidence that individual

leaders achieve similar results using different approaches, and despite having significant personal flaws (e.g., Hunt & Laing, 1997; McCall, 1998).

Following an analysis of the competency approach at an organizational level, and pointing to the impossibility of dissociating leadership from temporal and situational factors, Salaman (2004) concluded by proposing that, when applied to leadership (as with management),

“the problems it promised to resolve are not capable of resolution and its promise consisted largely of sleight of hand whereby organizational problems were simply restated as management responsibilities.” (p.75)

From a US perspective, Hollenbeck and McCall criticised what they saw as the four assumptions upon which the competency approach is based (Hollenbeck, McCall & Silzer, 2006). In these contexts, they commented, (1) that,

“As a descendent of the long-discredited “great man” theory, competency models raise again the spectre of one set of traits, abilities, and behaviours ... that make up *the* “great leader”.” (Hollenbeck *et al.* 2006, p.399);

(2) that effective leaders are not the sum of a set of competencies, and that the research of McCall (1998) and McCall and Hollenbeck (2002) demonstrates that

“What matters is not a person’s sum score on a set of competencies, but how well [or as we would put it, *in what way*] a person uses what talents he or she has to get the job done.” (Hollenbeck *et al.* 2006, p.399);

(3) that the tautological assumption that,

“Because senior management usually blesses competencies and sometime even helps generate them, they are the most effective way to think about leader behaviour” (Hollenbeck *et al.* 2006, p.399)

is correct; and

(4) that it has been suggested that, “When HR systems are based on competencies, these systems actually work effectively” (Hollenbeck *et al.* 2006, p.399). In contrast, Hollenbeck and McCall concluded that,

“we see little evidence that these systems, in place for years now, are producing more and better leaders in organizations.” (Hollenbeck *et al.* 2006, p.399),

and went on to point out that,

“[Of the companies that presentations about competencies at the first Competency Conference, in 1994] some have failed, some no longer exist, and many have struggled to survive ... Although we would not suggest that the advocacy of competencies by their HR people caused the problems the companies subsequently experienced, neither did the approach save them!” (Hollenbeck *et al.* 2006, p.406)

In response to a rejoinder by Silzer, the same authors went on to argue that, in their experience, “even when implemented effectively, competency-based systems have not worked (Hollenbeck *et al.* 2006, p.407).

In similar vein, although the latest ‘National Occupational Standards in Management and Leadership’ have recently been released (MSC, 2004), there remains significant doubt about the extent to which these really relate to improved or superior practice (Bolden & Gosling, 2004; Fuller, 1994; Grugulis, 1997, 1998, 2000; Holman & Hall, 1996; Swailes & Roodhouse, 2003). Indeed, most frameworks are singularly characterised by a lack of empirical evidence of their concurrent or predictive validity.

Related to this is the partial or questionable empirical evidence on which most competency frameworks are based. The initial research upon which NHS Leadership Qualities Framework (LQF) was based was derived solely from self-report data from Chief Executives and Directors (NHS Leadership Centre, 2003). Despite its limited provenance, and in spite of evidence that “depending on the role carried out, some [of the qualities] are more applicable to some staff than others” (Crowder & Woods, 2006, p.18), the LQF is applied across the *whole* of the NHS. It is ironic, then, that, at a time when a ‘one size fits all’ approach is being adopted in one part of the NHS, the leadership data collected by the Department of Health differentiate between the behaviours appropriate to Senior Managers, compared to those in a Middle Management or Supervisory role, within the NHS (Borrill, West & Jackson, 2005a & b).

More recently, the LQF has been criticised by Humphries (NHS Institute for Innovation & Improvement, 2006) for a number of reasons, including that it does not reflect a transformational approach to leadership. The revised version incorporates “in excess of 20” modifications. It is asserted that it now includes ‘transformational items’, though it does not appear to be made explicit which these are, nor how they can be scored to assess transformational leadership behaviour.

In contrast, the police ‘Integrated Competency Framework’ was devised on the basis of extensive research into the competencies required to be an effective officer or staff member at three different levels within police forces/services (ACPO, 2001). As such it provides a comprehensive framework, articulated in terms of twelve scales, for guiding the development of officers and staff in the full range of competencies that they will need to develop. In developing the framework, individuals at different levels and in different roles were consulted, and three different levels of competency have been identified. Similarly, the Fire and Rescue Service ‘Personal Qualities and Attributes’ framework was developed on the basis of extensive job

evaluation and work samples across all roles in the Service. It, too, is differentiated for staff at different levels (Evans, 2007; Fire Service College, 2006).

Fundamentally, then, the competency approach “reinforces a focus on the individual ‘leader’, while restricting consideration of ‘leadership’ as a distributed relational process” (Bolden & Gosling, 2006, p.148). As pointed out by Iles and Preece (2006), the distinction between leaders and leadership has significant implications for leadership development, particularly when there is a failure to appreciate the full complexity of leadership (Salaman, 2004). This is an issue which we go on to consider.

Chronologically, then, and from a theoretical perspective, competency frameworks can be seen to correspond to what we describe as Stage 2 thinking about the nature of leadership.

### **What about qualities and values?**

Before going on to consider why some competency frameworks, at least, do not deserve such a ‘bad press’, it is important to address a potential source of confusion. This is about the nature of ‘qualities’. Thus, for example, the competency framework developed for the NHS was entitled the ‘Leadership Qualities Framework’, and, as noted above, the Fire and Rescue Service framework identifies ‘Personal Qualities and Attributes’.

A ‘quality’ can be defined as a “peculiar and essential characteristic; nature; an inherent feature; a property; superiority in kind; a distinguishable attribute; a characteristic”,<sup>3</sup> and ‘values’ are “a person’s principles or standards of behaviour”.<sup>4</sup> On the other hand, a ‘competency’ is “the ability to do something successfully or efficiently”, and a ‘skill’ as “the ability to do something well; expertise”.<sup>5</sup> Thus, whereas as competency or skill involves some kind of action, a quality does not.

In the present context, personal qualities and values may be defined as

those cognitive and emotional characteristics of an individual that are essential pre-requisites of any kind of managerial or leadership behaviour.

Thus, for example, the personal quality of being ‘resilient’ or ‘tenacious’ is a requirement of someone who shows ‘competency’ in ‘negotiating and influencing’, just as ‘effective communication’ is a pre-requisite for ‘working in a team’. However – importantly – showing resilience or tenacity *does not guarantee* achieving a negotiated settlement, any more than being an effective communicator ensures effective team work. The possession of certain qualities and values are *necessary*, but *not sufficient*, for achieving

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<sup>3</sup> Longman Dictionary, 1990.

<sup>4</sup> New Oxford Dictionary of English, 1998.

<sup>5</sup> New Oxford Dictionary of English, 1998.

success. If a leader is to be competent, s/he must learn to draw upon their personal qualities and their attributes, and apply their values, in a certain way.

To use the terms 'qualities' and 'competencies' as if they were synonymous only serves to obfuscate where individuals' developmental needs may lie.

### **How can competency be defined?**

If we accept this definition of personal qualities and values, how can we offer a more appropriate definition of the additional characteristic of being competent? One way of approaching this is to suggest that,

A competent manager/leader may be defined as someone who enables the development of an organisation in a way that is *goal directed*, and geared to developing *processes and systems*. This enables staff at all levels to *plan effectively and efficiently*, in order to *achieve agreed goals*.

High levels of competency can lead to a *degree of consistency*, and thereby enable staff to make *day-to-day decisions* and *short-term predictions*, with a measure of confidence. Leadership competencies, which are often largely closed-ended in nature, are necessary in order that staff can undertake *strategic planning*, and in this way help to turn the *vision* of an organisation, department or team *into a reality*.

Acceptance of such a definition leads to the conclusion that being competent is an essential characteristic of anyone who occupies a management or leadership role. However, it is equally true, particularly in the light of the earlier criticism, that competency on its own is not enough.

To re-cast the phrase used earlier, being competent is *necessary*, but *not sufficient*, for being a leader.

### **What else is required?**

The answer to this question is that, if being competent can be thought of as the 'what' of that which leaders do, then that which enables a leader to take on a *leadership* role is the 'how'. And the how of leadership is the way in which it is enacted – whether it be in a (post-heroic) 'transformational' or a 'non transformational' way.

In the light of our research into the nature of 'nearby' transformational, or 'engaging' leadership – since engagement is what a 'nearby' transformational style of leadership strives to achieve – we propose the following definition:

A '*nearby*' transformational or engaging leader may be defined as someone who encourages and enables the development of an organisation that is *characterised by a culture* based on *integrity, openness* and *transparency*, and the *genuine valuing of others*.

This shows itself in concern for the development and *well-being of others*, in the ability to unite different groups of stakeholders in articulating a *joint vision*, and in delegation of a kind that *empowers* and *develops potential*, coupled with the *encouragement of questioning* and of *thinking which is critical* as well as *strategic*.

Engaging leadership is essentially open-ended in nature, enabling organisations not only to *cope with change*, but also to be *proactive in shaping their future*. At all times engaging leadership behaviour is guided by *ethical principles*.

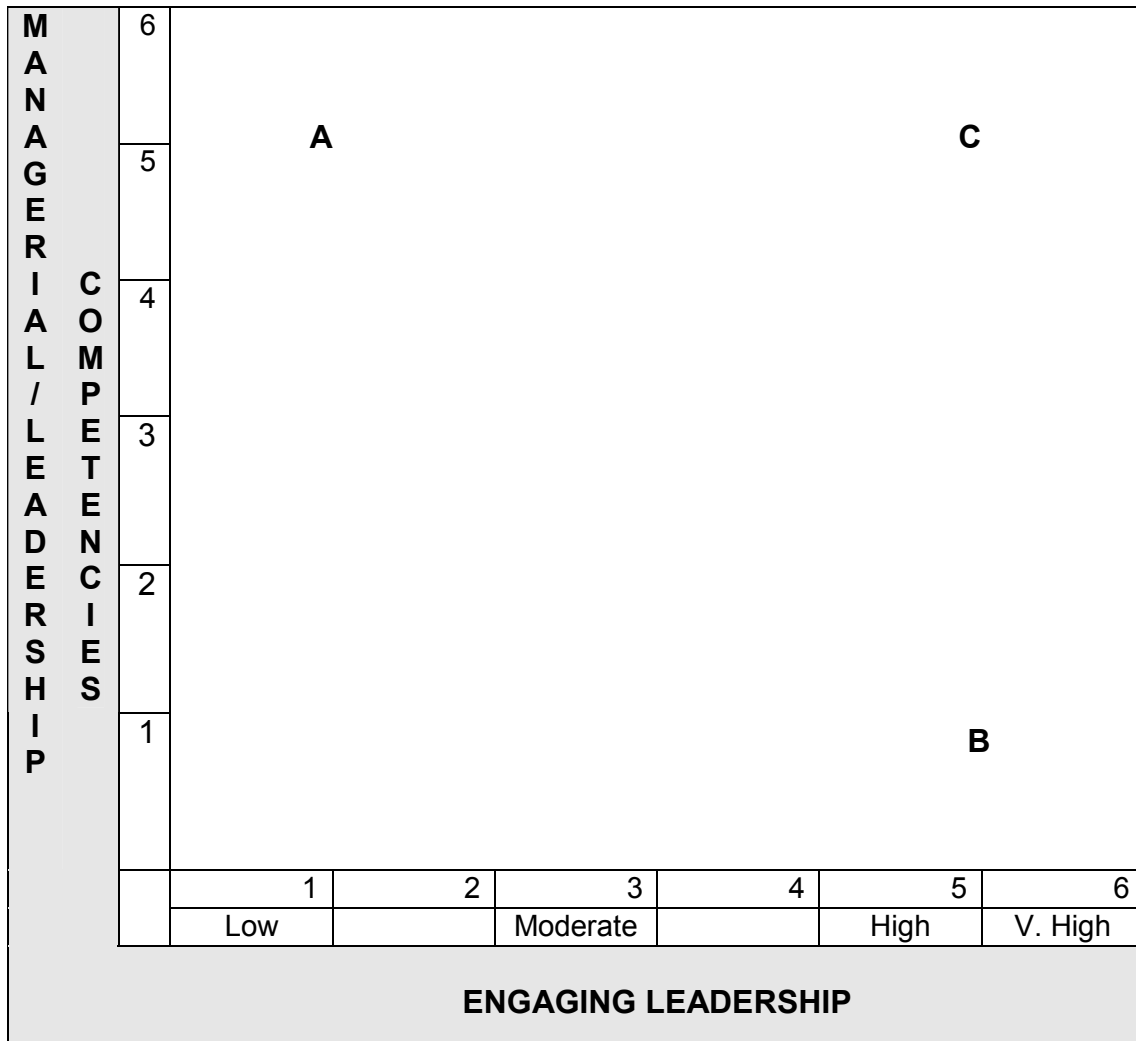
The relationship between managerial/leadership competency and engaging leadership is summarised in Figure 1.1 (next page). Thus, person A can be seen to be highly competent, but not very engaging in their behaviour; perhaps the kind of person who is very detailed in their planning, or can devise very effective systems for quality control, but who shows a lack of understanding of, or concern for, the needs of others.

Conversely, person B is someone who, perhaps, shows great concern for others, and creates a supportive environment in which all staff are valued, but who is unable to deliver what is required of them in terms of achieving goals or meeting agreed targets on time. Such a person's style of leadership is highly engaging, but they show a low level of competency.

Person C, then, is the kind of manager or professional who, by acting in an engaging way, with all that entails, can use their competency as a leader in ways that are relevant to the particular situation. In other words, their actions are situation-sensitive.



**Figure 1.1 – Relationship between managerial/leadership competencies and engaging leadership behaviour**



**How do they fit together?**

The short answer to this question is that what we would describe as ‘managerial/leadership competencies’ and ‘engaging leadership’ behaviours are complementary. For the longer answer, two similes are apposite. Thus, using an analogy from art, Alimo-Metcalfe and Alban-Metcalfe (2005b) suggested that anyone could paint a Monet if one could deconstruct a beautiful painting into a ‘painting by numbers’ exercise.

Bolden and Gosling (2006) offered a musical simile:

“a competency framework could be considered like sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life.” (p.151)

Put another way, as we go on to discuss, competencies can be thought of as the 'what' of leadership – what is missing is the 'how'.

In this context, it seems to us to be naïve to suggest that the 'how' can be assessed by simply adding on a number of 'transformational' or 'engaging' items. Rather, it is the '*structure d'ensemble*' that is the unitary element here.<sup>6</sup> In other words, how one 'acts in an engaging way' can only be assessed with reference to a number of relevant, inter-related and inter-acting dimensions.

How 'being competent' and acting in an 'engaging' way fit together can also be understood in the relationship between leader development and leadership development.

### **Leader development and leadership development**

The difference between these two concepts was noted by Bolden and Gosling (2006), who drew a distinction between approaches to the study of 'leaders' as distinct from 'leadership'. The same issue has been addressed by Iles and Preece (2006), in a more widely ranging analysis.

Developing a theme that they initially addressed concerning the development of managers as distinct from management development (Dale & Iles, 1992), Iles and Preece (2006) have pointed to fundamental differences between 'leader development' and 'leadership development'. As they point out,

“Leader development refers to developing individual-level intrapersonal competencies and human capital (cognitive, emotional, and self-awareness skills for example), while leadership development refers to the development of collective leadership processes and social capital in the organization and beyond, involving relationships, networking, trust, and commitments, as well as an appreciation of the social and political context and its implications for leadership styles and actions.”  
(p. 325)

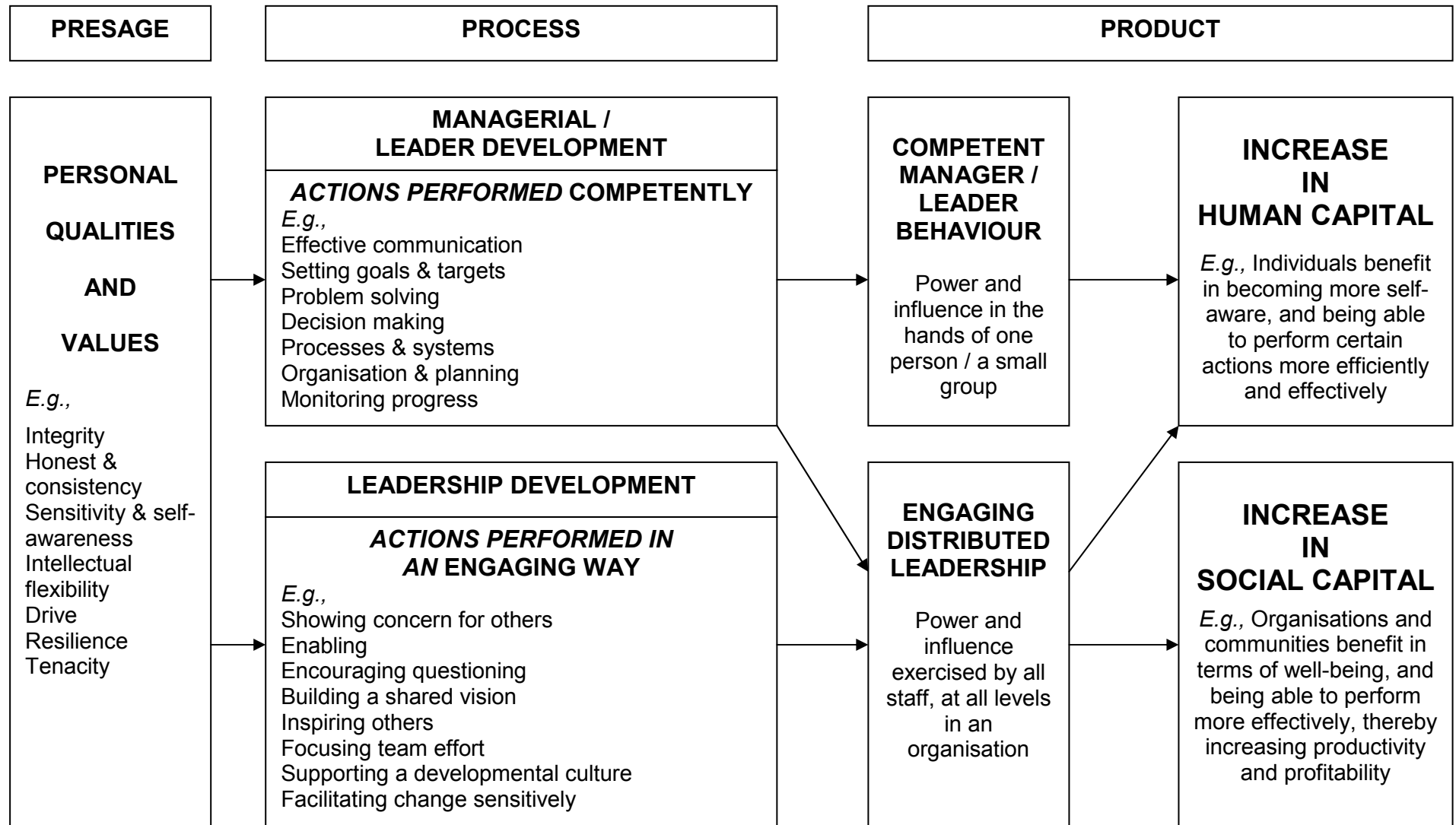
Thus, “Leadership development involves the development of leadership processes in addition to the development of individual leaders” (Iles & Preece, 2006, p.323).

Leadership development, therefore, which is predicated on a 'distributed' model of leadership, is about enabling individuals and groups to work together in meaningful ways (cf. Day, 2000). It has, as its goal, the building of social relationships involving all members of the community in order to respond proactively and effectively to changing circumstances, and thereby achieve organisational and societal goals.

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<sup>6</sup> The *structure d'ensemble* is the relationship between the individual items and the structural whole (e.g., Piaget & Inhelder, 1969).

**Figure 1.2: Relationship between leader development and leadership development**



In other words, leadership is about behaving in an *engaging* way, and leadership development is – or should be – concerned with enabling leaders to combine *what* they must do as leaders, with *how* to interact with others in ways that will enable them, and their colleagues, to be optimally effective.

Put simply, the relationship between personal qualities, competent management/leadership, and transformational leadership can be expressed as in Figure 1.2.

Thus, through the process of managerial or leader development, an individual can draw upon their personal qualities and values ('presage' characteristics) in such a way as to become a competent manager/leader. This process results in competent leader/manager behaviour, and an increase in *human capital*, whereby individuals are the principal beneficiary in that they become more self-aware, and more able to perform certain actions more efficiently and more effectively.

Similarly, the development of the same competencies, coupled with the development of 'engaging' leadership behaviours, can enable the individual to show the behaviours that characterise distributed leadership. Distributed leadership behaviours result not only in an increased in human capital, but also an increase in *social capital*, which takes the form of organisations and communities benefiting in terms of well-being, and being able to perform more effectively, thereby increasing productivity and profitability.

## Conclusion

What this paper set out to do was to analyse the nature of competencies, both for what they are and for what they are not, and to place them in a chronological context. With regard to the first of these, one might paraphrase a comment made by Neil Kinnock<sup>7</sup> in another context: competencies can be likened to Brighton Pier, very fine in their own way, but not a good way of getting to France.

What we are not arguing for is the abandonment of competencies and competency frameworks; quite the reverse. What we are arguing is for is two things, both of which relate to the concept of 'fitness for purpose'. One, is to ensure an improvement in the quality of such frameworks. This can be only be achieved if certain quality-related steps are taken. These include: (1) undertaking empirical *sector-specific research* to ensure that what is assessed is relevant to managers and professionals working in that area, rather than being generic; (2) if different 'levels' of competency are to be assessed, ensuring that there is *continuity*, rather than disjunction, in the competencies required of staff at different levels, and in different roles<sup>8</sup> – most of the

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<sup>7</sup> Based on his description of the 1981 Education Act, when he was Shadow Spokesman on Education.

<sup>8</sup> The analysis undertaken by Stockton-on-Tees Borough Council (2007) of the competency framework for Elected Members, developed by Real World Group, provides a good example of how this can be done.

National Curriculum tests in England are good examples of how not to achieve this; (3) ensuring, as far as possible, that each competency statements refers to only one aspect of leadership behaviour – though, in practice, this can be hard to achieve.

The other, is to ensure that competencies are not assessed in isolation. Here, what is desirable is to assess *both* what a leader does *and* how s/he does it. The goal is not assess just the leader's human capital, but also to assess how to turn human capital in *social capital* (see Figure 1.3).

As far as assessment is concerned, the super-ordinate construct is to note that neither leadership competency, nor transformational leadership is superior to the other. Indeed, quite the reverse is true; for effective leadership *both* are required, since they are *complementary* to one another. The key to success, then, is to try to perform competently, in a transformational way.

Thus, leadership development, which is predicated on a 'distributed' model of leadership, is about enabling individuals and groups to work together in meaningful ways (cf. Day, 2000). It has, as its goal, the building social relationships involving all members of the community in order to respond proactively and effectively to changing circumstances, and thereby achieve organisational and societal goals. In other word:

“While leader development focuses on individual-level knowledge, skills and abilities and interpersonal competencies such as self awareness and emotional awareness, self-regulation and self-motivation ...” (Iles & Preece, 2006, p.324),

leadership development can be analysed in terms of the three dimensions of social capital, as articulated by Nahapiet and Ghoshal (1998). These are:

- Structural – social interactions, which can be developed through networking and gaining the commitment of others;
- Relational – networks of inter-acting relationships, based on trust and trustworthiness;
- Cognitive – shared representations and collective meanings, such as cultures and shared visions, based on common values.

Consistently with the analyses of Fiedler (1996), interaction between individuals and their social and organisation environment must be at the heart of any kind of leadership development.

360-degree and other multi-rater feedback, both on individual performance and on the performance of organisations and teams, can provide valuable sources of information in guiding how the goal of increasing social capital can be achieved. This can only, however, be effective if the right questions are asked (i.e., the relevant dimensions are identified), and the questions are asked within a developmental context.



Figure 1.3 – Relationship between Leader Development and Leadership Development

The decision to use the ‘Leadership Climate and Change Inventory’ (LCCI)<sup>™</sup> in the present investigation reflects sensitivity to these issues. This instrument has, as its provenance, a model of ‘engaging leadership’ of a kind that can inform understanding of the ways in the ways in which social capital can be developed, complemented by a competency-based analysis of the ways in which leadership can be assessed.

## **Leadership, Attitudes to Work, Well-being at Work, and Organisational Performance**

The research by Bass and others established statistically significant correlations between ratings of direct reports on the MLQ and the outcome variables assessing two aspects of satisfaction (job satisfaction; satisfaction with leadership style) and two aspects of motivation (motivation to achieve; motivation to achieve beyond own expectations). There is also substantial evidence that a transformational style of leadership is positively associated with organisational performance in a wide range of private and public sector organisations (see Bass, 1998, for an extensive review).

Similar relationships have also been reported involving the 'Transformational Leadership Questionnaire' (TLQ) (Alimo-Metcalfe & Alban-Metcalfe, 2001). These authors reported significant correlations between each of the nine scales that comprise the local government version of the TLQ both with the same attitudes to work metrics used by Bass, and with a reduced level of job-related stress. They also provided evidence from multiple regression and discriminant functional analyses of different patterns of relationships between leadership behaviour and the effect on staff for male versus female staff, and for staff at different levels in their organisation (Chief Executive to middle management level), among managers and professionals in the NHS ( $n = 2,103$ ) and local government ( $n = 1,464$ ) (Alban-Metcalfe & Alimo-Metcalfe, 2000a, b).

A Canadian study of leadership in 31 multi-professional community mental health teams working with adults with severe and persistent mental health problems (Corrigan *et al.*, 2000), sought to investigate whether there was a relationship between transformational and transactional leadership styles, and service users' perspectives of the programmes they had adopted.

The teams worked in state hospitals and community-based mental health programmes, providing psychopharmacological and psychosocial treatments. They comprised between nine and forty-one members, and provided skills training, supported employment services, assertive community treatment, and drop-in services.

Data relating to the team leader's leadership style were gathered from using the MLQ instrument (Bass & Avolio, 1990) to measure transformational and transactional leadership, and both leader and subordinates rated the leader's style, while service users reported their satisfaction with services and their quality of life, by completing the Patient Satisfaction Scale (PSS). To avoid possible 'halo' or 'horns' rating responses, service users were asked to rate the PSS items by comparing their current treatment with another programme in which they had participated, using a 7-point scale in which 7 indicated the best treatment they had ever received, 6 indicating that current treatment was much better, and so on. The ratings were summed to obtain an overall satisfaction score, the higher the score, the greater the satisfaction with the current treatment programme. Reliability and construct validity was judged to

be satisfactory from previous research studies, although references were cited rather than specific figures in the paper.

The quality of life measure selected was the subjective component of Lehman's Quality of Life Interview (QOLI) (Lehman, 1983), because the authors assert that it has been tested with the largest sample of people with severe mental illness, and that when it had been used in three independent research samples, the QOLI index of subjective quality of life was shown to correlate with objective measures of the same construct.

Data were gathered from 143 leaders (70.7% females) who rated themselves in terms of how they thought their subordinates viewed them, and 473 subordinates rated their leaders with respect to the frequency of using the range of leadership behaviours. A total of 184 service users rated the teams in terms of how satisfied they were with the programme they offered, and how it affected their quality of life.

Service users' satisfaction and quality of life ratings did not correlate significantly with demographic characteristics of the leaders. However, two demographic characteristics of the subordinates did correlate significantly with users' satisfaction; age was inversely related ( $r = -.32$ ;  $p < .05$ ), and their educational level correlated positively ( $r = .34$ ;  $p < .05$ ).

The total consumer satisfaction score was significantly correlated with the four transformational dimensions as rated by the leaders of themselves. That is, the users supported by teams in which the leaders rated themselves as high in Inspirational Motivation, also reported high satisfaction with their programmes. Also, leaders who rated themselves as low in the use of passive management-by-exception and laissez-faire leadership style, worked in programmes which users rated high in satisfaction. Thirdly, leaders who reported that their style was likely to be perceived as high in the use of contingent reward with their staff (i.e., transactional leadership), were also working in programmes that obtained high satisfaction ratings from service users.

The pattern of correlations with subordinates' ratings of their team leader's style, was different. Subordinates who perceived their team leader as high on active management-by-exception rated their programmes low in satisfaction. Subordinates who viewed their leaders as charismatic, inspiring, and displaying consideration towards the interests of staff members, were more likely to work in programmes where users rated their quality of life as higher. Although leaders' ratings did not correlate significantly with users' quality of life ratings, the authors conclude that the relationship between leaders' self ratings of use of laissez-faire leadership, and quality of life scores of users indicated non-significant trends ( $p < .10$ ).

Stepwise multiple regression analyses determined that both leaders' and subordinates' ratings of the leaders' style, accounted for independent variance in users' quality of life ratings, adding that, in particular, subordinates' ratings of leaders' individualised consideration of their staff, and leaders' ratings of



their laissez-faire leadership as perceived by their subordinates, were associated with quality of life of users, accounting for 28% of the variance.

Since this was a cross-sectional study, causation cannot be assumed between the use of transformational leadership by the team's leaders, and satisfaction and quality of life of the users they support. The authors conclude that since the leadership variables only accounted for 40% of the variance in users' satisfaction and quality of life, future research should examine the possible effects of the treatment culture and staff burnout, which might interact with leadership, or account for independent variance in these outcome variables.

Finally, the authors note with disappointment the difference between the correlation matrices between users' ratings of impact of the treatment, and the ratings of leadership by the leaders themselves, and the ratings of leaders by their subordinates. They recommend that future research "identifies constructs that mediate the effects on consumers' (service users') ratings of subordinates' versus leaders' perceptions" (p.784).

In another study, Borrill, West and Jackson (2005a) examined the relationship between leadership, people management, staff satisfaction and intention to leave using 2003 National Staff Survey data for 203,911 staff in 572 NHS trusts. Senior management leadership was assessed on a 'yes', no' or 'don't know' basis on a five item scale which measured: - clarity of organisational vision; support for new ideas; being focused on meeting patient's needs; relationships with the community; links with other organisations (Cronbach's alpha coefficient for the scale = .93). Supervisory/manager level leadership was assessed on a six item five-point scale ('strongly agree' to 'strongly disagree'). The items were concerned with measuring: - encouraging staff to work as a team; staff clarity about the nature of their job; providing support to staff with difficult tasks; clear feedback to staff about their work; seeking staff opinions before taking decisions that affect them; being supportive in a personal crisis (alpha = 0.91).

In both cases, the dependent variables were: -

- Human resource management practice: quality of staff appraisal; presence of a personal development plan; existence of training during previous 12 months; structure of team environment; witness to harmful errors or near misses; work related illnesses or injuries; experience of physical violence; experience of harassment, bullying or abuse; quality of work-life balance. These were assessed on a scale for which Cronbach's alpha was 0.85.
- Outcomes for staff: job satisfaction, measured on a seven item five-point scale ('very dissatisfied' to 'very satisfied'), for which alpha = 0.87; intention to leave, measured on a four item five-point scale ('very dissatisfied' to 'very satisfied'), for which alpha = 0.92.

Regression analyses were used to explore relationships at an organisational level between leadership (senior and supervisor/manager) and human

resource performance, assessed in terms of management practice. Corresponding multi-level analyses at an individual level examined relationships between leadership and outcomes for staff.

In all types of trust, overall positive relationships were detected between perceptions of senior management leadership and staff appraisal and the use of personal development plans, while supervisor/manager leadership was related to staff appraisal and work-life balance. A strong link was shown to exist between work-life balance and senior management leadership in acute/specialist, mental health and primary care trusts.

There were also overall positive relationships between both senior and supervisor/manager leadership and both job satisfaction and reduced intention to leave. Both relationships involving supervisors/managers were stronger than those for senior managers.

At an individual level, perceptions of the quality of leadership at both senior and supervisor/manager levels were significantly related both to job satisfaction and reduced intention to leave. Again, the relationships involving supervisors/managers were stronger than for senior managers.

Lastly, within acute/specialists and mental health trusts senior management leadership was more strongly associated with positive experiences of human resource management practices than among supervisors/manager (Borrill *et al.*, 2005a).

Differences in the strength of the relationship between leadership at a supervisor/manager level rather than senior level and both job satisfaction and intention to leave may be interpreted in terms of differences in the kind of leadership behaviours measured. The five items used with the senior managers could be interpreted as reflecting a 'strategic' perspective which tends to be associated with 'distant' leadership, while with the supervisors/managers, the emphasis was on 'day-to-day' practice, which is more characteristic of 'nearby' leaders.

Alternatively, it may be that the job satisfaction for staff at higher levels in NHS trusts is less a function of their perceptions of leadership behaviour than those at lower levels, and also that the way in which their leader(s) act is less likely to affect any decision staff at higher levels take about leaving the organisation.

A second study by Borrill, West and Dawson (2005b) explored the relationship between leadership and trust performance, using random stratified samples of the 5,564 staff in 33 hospitals who provided Staff Involvement Research data for 2001, and the CHI Clinical Governance Review for October 2001 - December 2002 for 18,156 staff working in 101 trusts.

Top management team leadership was assessed on a six item five-point scale ('not at all' to 'a great deal') which assessed the extent to which the top management team: - described exciting new opportunities; proposed new and creative ideas; was effective in leading the organisation to meet patients'

needs and care for their safety; took account of both service requirements and staff needs in implementing major change; build positive links with the community; built co-operative links with other organisations (alpha = 0.91). A four item five-point scale ('not at all' to 'a great deal') was used to assess supervisor/manager leadership: - encourages giving of best effort; offers new ideas to solve problems; encourages team working; has patients' interests at heart (alpha = 0.92).

For both groups, the dependent variables were: -

- Organisational factor: - a seven item five-point scale ('strongly disagree' to 'strongly agree') assessing the importance attached to developing innovations in patients care (alpha = 0.93);
- Staff well-being: Job satisfaction, measured on a six item five-point scale ('very dissatisfied' to 'very satisfied') (alpha = 0.83); Intention to leave, measured on a four item five-point scale ('very dissatisfied' to 'very satisfied') (alpha = 0.90);
- Trust performance: Star rating; Patient satisfaction, assessed on four items, using a five-point scale ('very poor experience' to 'excellent experience') (alpha = 0.77); number of complaints; CHI Clinical Governance Review ratings, assessed in relation to seven dimensions on a five-point ('0' to '4').

Top management leadership and supervisor/manager leadership were positively correlated with job satisfaction ( $r = 0.34$ , ns;  $r = 0.45$ ,  $p < .01$ ). These results are consistent with the earlier findings in that there is a stronger relationship with the perceptions of the leadership of the supervisors/managers. Negative correlations were found between intention to leave and leadership at both levels and job satisfaction, but the coefficients did not reach the level of statistical significance.

In terms of outcomes, neither top management nor supervisory leadership was significantly correlated with trust star rating ( $r = 0.17$ , ns) or patient satisfaction ( $r = 0.10$ , ns). Significant positive correlations ( $p < .05$ ) were detected between ratings of both senior and supervisory leadership and clinical governance ratings for education and training, risk management, and patient involvement. Furthermore, clinical governance ratings for clinical audit, clinical effectiveness, and use of information were significantly positively correlated with ratings of top management leadership ( $p < .05$ ).

### **Organisational Culture/Climate**

There is much confusion in the literature about the nature and definition of 'organisational culture' and 'organisational climate', and of the further concepts of 'psychological climate' and 'collective climate', which reveals the need for consistent use of the terminology. At the same time, it is also true that many of these terms are used interchangeably (Ashkanasy *et al.*, 2000; Parker *et al.*, 2003).

Psychological climate is something that is unique to the individual. It can be thought of as the way in which an individual makes psychologically meaningful representations of the world around, with particular reference to organisational structures, processes and events. These internal representations of structures, processes and events enable the individual to interpret events, to predict possible outcomes and to gauge the appropriateness of their subsequent actions. Clearly the way in which an individual interprets what they perceive is influenced by their own personal values and that what they know about the values of the organisation in which they work, or with which they are associated.

Psychological climate is generally accepted as “the property of the individual and that the individual is the appropriate level of theory, measurement and analysis.” (Jones & James, 1979). It is relevant to organisational culture insofar as it is affected by organisational values, and in terms of investigations, employees’ perceptions of virtually every aspect of their work environment, including the characteristics of their jobs, physical environment, supervision, top management, and co-workers have been included in psychological climate research.

Collective climate is a group-level construct that is often calculated by aggregating psychological climate perceptions, using statistical techniques, such as cluster analysis. The aim is to identify collections of individuals who share similar psychological climate perceptions. Parker *et al.* suggest that such an aggregation is not a legitimate way of conceiving of, or measuring, climate at a group level, since the question to be asked is whether such data are of socio-psychological significance or statistical artefacts. If the latter, then data collected in this way should be analysed at the individual level (Parker *et al.*, 2003).

Organisational climate may have either a subjective or objective focus. When the focus is subjective, it corresponds to what members of a group of collectively understand and share as their experiences of organisational structures, processes and events. It is the result of sense-making processes which lead to shared perceptions – a ‘social collective’ – that is inextricably linked to the way in which individuals interact with one another.

From an objective focus, it is a property of the organisation itself and represents employees’ descriptions of an area of strategic focus or organisational functioning, such as customer service, innovation, transfer of training, or safety. This focus is rooted in the admonition that climate must be ‘for something’ (Schneider, 1995). It has been suggested that organisation climate is a descriptive, not an evaluative concept, as in the case of, say, job satisfaction. However, as Patterson, Warr and West (2004) point out, some of the items in climate questionnaires have an obviously value-laden content, and point to broader psychological research that points to the inseparability of descriptive and evaluative perceptions. The position adopted by Patterson *et al.* (2004), which is the one adopted here, is that “the concepts of climate and affect are conceptually distinct, but that perceptions of climate are usually tinged with some degree of affect” (p.4).

When used in both of these senses, the term 'organisational climate' is frequently used synonymously with 'organisational culture'

Organisational culture may be defined as:

“A pattern of basic assumptions – invented, discovered, or developed by a group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those processes.” (Schein (1985, p. 9).

These assumptions, which include what is right, what is good and what is important, form the basis for consensus and integration. Furthermore, they encourage motivation and commitment to meaningful membership and provide organisations with purpose, meaning and direction. The development of an organisational culture leads to the emergence of 'heroes', 'stories', and 'rituals', which are expressions of the ways in which the individual members bond together (Bass, 1985, 1998; Denison & Mishra, 1995; Hunt, 1996). Indeed, organisational culture has been described as the 'glue' that holds the organisation together and that stimulates employees to commit to the organisation and to perform.

It has been defined operationally as, “shared perceptions of organisational work practices within organisational units that may differ from other organisational units” (Van den Berg & Wilderom, 2004), or the “particular ways of conducting organizational functions that have evolved over time ... [These] practices reflect the shared knowledge and competencies of the organization” (Kostova, 1999).

The extent to which metaphorical glue affects the culture of organisations within the NHS must be understood within the context of the two sub-cultures that exist – the medical and the managerial (Davies, Nutley & Mannion, 2000). One of the many questions is the extent to which organisations such as the NHS – and by the same token universities – share perceptions of organisational work practices. What is certain is the basis on which mental health crisis resolution and home treatment teams were formed differs fundamentally from the practice in other mainstream healthcare provision (e.g., McGlynn, 2006).

According to Schein's three-level typology of organisations, it is possible to distinguish:

- Assumptions – taken for granted beliefs about human nature & the organisational environment that resides deep below the surface
- Values – shared beliefs and rules that govern the attitudes and behaviour of employees, making some modes of conduct more socially and personally acceptable than others.

- Artefacts – the more visible language, behaviours, and material symbols that exist in organisations (Schein, 1990).

Some writers have focused on values in defining organisational culture, though research suggests that while values are important elements of organisational culture, organisations show more differences in practices than in values (Hofstede, 2001). This supports the view that organisational culture can better be defined by organisational practices. This is consistent with the observation that values, which of their nature are not visible, are assumed to be expressed, in part, in organisational practices. Therefore, values can be inferred from existing and espoused practices. Furthermore, organisations have been found to differ more strongly in practices than in values (Wilderom & Van den Berg, 1998).

A ‘strong’ organisational culture is defined as one in which employees have the same set of values (cf. Peters & Waterman, 1982), and a limited number of academic studies provide evidence of a strong link between a strong organisational culture and organisational performance. However, many empirical studies fail to establish a clear connection between conceptual and operational definitions of cultural strength. It has also been pointed out that ‘strong’ is only an indication of the degree of employee consensus, but *not* of the desirability (ethical or otherwise) of that culture on the different dimensions that can be used to assess it. It is too limited an epithet for describing), let alone measuring, a phenomenon as complex as the culture of an organisation.

Van den Berg and Wilderom (2004) suggest that the focus of investigations should be on perceptions of organisational practices, rather than their objective occurrence. They go on to observe that organisational culture is a perceptual, rather than an organisational phenomenon, that is observed or registered by individual employees, and that “capturing the perceptions of a representative sample of employees ... should be part of any assessment of an organisation’s culture”.

Their definition of organisational culture is similar to organisational, insofar as the latter has been typically conceived as employees’ perceptions of observable practices and procedures, and point out that “both culture and climate studies focus on the internal social psychological environment as a holistic, collectively defined context and ... there is a high overlap between the dimensions used”. Indeed, measures of perceived culture have sometimes been made through questionnaires similar to those applied in climate studies (e.g., Reichers & Schneider, 1990; Payne, 2000).

However, although these writers do not stress a distinction between organisational culture and climate, an important distinction can be drawn by suggesting that:

- culture “refers to the deep structure of organisations”, whereas

- climate mainly concerns “those aspects of the social environment that are consciously perceived by organizational members” (Denison, 1996, p.624).

Furthermore, in contrast to the descriptive focus of organisational climate, organisational culture has a normative focus; in other words, it attempts to capture members’ values, beliefs, and assumptions as to the appropriate way to think, act, and behave (Schein, 1990). Indeed, Schein describes organisational climate as one surface-level manifestation of an organisation’s culture, such that individuals’ values and prescriptive beliefs become codified into organisational structures, systems and processes, which then guide the collective behaviours that are measured as organisation climate perceptions.

*Organisational capabilities* are the, perhaps unique, bundles of heterogeneous resources and capabilities that an organisation has at its disposal, which give it a competitive advantage (Teece *et al.*, 1997). These capabilities include the effectiveness of organisational and managerial processes, the current endowment of technology and intellectual property, and the strategic interventions necessary for sustained business performance.

It is useful to distinguish three kinds of capabilities:

- Dynamic capabilities, which are required for successful change, including the capacity to renew competencies so as to achieve congruence with the change business environment
- Operational capabilities, which are required for sustaining everyday performance, but which do not generally help organisation to manage change effectively. Indeed, many capabilities required to achieve change implementation are very different from these
- Reshaping capabilities, of which there are three kinds
  - Engagement capabilities, which are based on informing and involving organisational members in attempt to encourage motivation and commitment to goals and objectives
  - Development capabilities, which are involved in developing all resources and systems needed to achieve future directions
  - Performance management capabilities, which include acting proactively to manage the factors that drive organisational performance, so as to ensure consistent and effective achievement.

Strength in reshaping capabilities is strongly positively related to rate of change implementation success, but has a weaker relationship with current business success. Performance management capabilities are important in both contexts.

Thus, we would suggest that,

Organisational capabilities include specialist knowledge and intellectual property, understanding of how the organisation operates, and goal directed activities that are geared to developing processes and

systems. Such behaviour enables efficient and effective planning, so as to achieve agreed goals, both short-term and long-term.

High levels of organisational capability can lead to a degree of consistency within a team, department or organisation, thereby enabling staff to make day-to-day decisions and short-term predictions, with a measure of confidence. Organisational capabilities are essential to any organisation, and enable staff to undertake strategic planning, and in this way help to turn the vision of an organisation, department or team into a reality.

### *Levels and Dimensions*

Culture and climate can be analysed at any of a number of different levels: - national; whole organisations; department or service; team; subgroup within an organisation, department, service or team. Van den Berg and Wildrom believe that “company-wide cultures can only be assessed accurately through team-level assessments ... [and that within] each team a certain degree of ‘shared perceptions’ about their organisational work practices can be established”. They go on to observe that “How to compare these ‘shared perceptions’ of one group to another meaningful comparison group is the key question that remains” (Van den Berg & Wildrom, 2004).

They went on to propose the following dimensions:

- autonomy – the degree to which an employee has decision latitude in their job;
- external orientation – the extent to which a group (e.g., team, department) is orientated to meeting the needs and aspirations of external stakeholders. This is seen as very much part of its internal functioning, and may involve inter-agency cooperation;
- interdepartmental coordination – the extent to which there is cooperation between teams, department and services within an organisation. This can be affected, in part, by the extent to which any kind of horizontal differentiation may raise barriers to productive inter-departmental communication;
- human resource orientation – the extent to which there is a genuine recognition of the value of the human resources that exist, coupled with the extent to which such recognition manifests itself in respect for staff. This is seen as an explicit organisational culture construct;
- improvement orientation – the degree to which an organisation’s level of ambition to improve is reflected in a similar orientation among staff. It shows itself, at a minimum is at least a positive orientation towards improvement, and includes the degree to which staff are proactive in achieving better organisational results

On the basis of a meta-analytic study of 121 independent samples, in which climate perceptions were measured and analysed at the individual level, Parker and colleagues identified three models that share in common the feature that they had cited theoretical and factor analytic studies of earlier researchers Parker *et al.* (2003).



The criteria adopted were: Does the model provide adequate cover of the psychological climate domain? Does the model facilitate unambiguous assignment of psychological climate dimensions to specific categories? Does the underlying theory apply at an individual level? Has subsequent research supported the construct validity of the model through empirical techniques, e.g., factor analysis? On this basis, three models were identified:

Model 1 identified the following five dimensions:

- goal emphasis
- means emphasis
- reward orientation
- task support
- socio-emotional support (Kopelman, Brief & Guzzo, 1990).

This they rejected because, although a cogent case can be made for how ratings on these dimensions influence attitudes and motivation, other outcomes (e.g., job challenge, autonomy) are not readily integrated into the model.

Model 2 distinguished between the following aspects:

- affective (related to people)
- cognitive (related to psychological involvement)
- instrumental (related to task involvement) (Ostroff, 1992).

However, these categories have been criticised since they represent dimensions that would be aggregated and analysed at organisational, not individual, level. Also, at a practical level, it is difficult to assign certain dimensions (e.g., 'role ambiguity') without making presuppositions (Is it cognitive or affective?).

Model 3 involves a situational referents analysis in terms of:

- job characteristics, e.g., autonomy, challenge, importance
- role characteristics, e.g., ambiguity, conflict, overload
- leadership characteristics, e.g., goal emphasis, support, upward influence
- work group & social environment characteristics, e.g., cooperation, pride, warmth
- organisational and subsystem characteristics, e.g., innovation, management awareness, openness of information (Jones & James, 1979).

Subsequent research, using confirmatory factor analysis of data from a variety of sources, has generally supported this framework (Jones & James, 1989; Parker *et al.*, 2003).

In their recent study of 'organisational 'climate', based on a sample of 5,415 employees from 54 organisations, Patterson *et al.* (2004) examined the relationship between attitudes to work in relation to 17 climate dimensions. These were: involvement, autonomy, supervisory support, integration, concern for employee welfare, skill development, effort, reflexivity, innovation and flexibility, outward focus, goal clarity, pressure to produce, quality, performance feedback, efficiency, formalization, tradition.

The latter are more concerned with the mostly 'non-human' aspects of organisations – organisational effectiveness, managerial processes, endowment of technology and intellectual property, strategic interventions necessary for sustained business performance. What each of these approaches has in common is that they refer to what individuals – both internal and external stakeholders – perceive the organisation to be like. As such, it corresponds to the reality that they experience.

What emerges, then, is that different researchers have adopted different operational definitions of culture and climate, which suggests the need for caution in interpreting the results of different studies. In particular, it is important to distinguish between those studies in which the focus of attention is on different aspects of 'climate' (psychological, collective, organisational), as distinct from those which set out to investigate the 'culture' of organisations. At the same time, it would seem useful to distinguish between, on the one hand, the different definitions of organisational culture and climate, which are concerned with values and the way in which individuals interact with one another, and on the other, organisational capabilities.

*Readiness for change* is an aspect of organisational culture/climate that is particularly relevant at a time when there is an almost constant change, combined with a drive for improving efficiency and a plethora of targets against which performance is judged, with the pressures that this inevitably places on employees. Organisations, therefore, need to pay increasing attention to the factors that affect individuals' ability to cope with change, and the impact that such processes can have on the performance and psychological well-being of staff. Lack of such attention will have repercussions on outcomes, such as increased absenteeism and turnover, which are, in themselves, financially costly to an organisation (CBI, 1999), and in particular one the size of the NHS, employing around 1.3 million staff. The potential damage of the high levels of stress suffered, to the individuals affected, is potentially, incalculable.

A number of factors have been identified that affect individuals' responses to change. Among these are the belief that one can accomplish change successfully, referred to as a sense of 'self-efficacy', and having an opportunity to participate in the change process (Armenakis, Harris, & Mossholder, 1993). Researchers such as Prochaska *et al.*, (1994), have emphasised the importance of organisations enabling employees to recognise the benefits that change can bring, while other writers stress the need to appreciate the risks of not changing (e.g., Armenakis *et al.*, 1993; Beer, Spector, 1989).

In their examination of variables affecting readiness for change, Cunningham *et al.* (2002) cite a number of studies that have identified workplace contributions to readiness for organisational change, including feeling empowered in one's job, believing one possesses the skills attitudes, and opportunities to manage change, which, in turn, affect work-related self-efficacy.

In their longitudinal study of a range of professional and non-professional hospital staff, they found that staff who occupied jobs which provided higher decision latitude and control over challenging tasks reported a higher readiness for organisational change. The same was true for staff in jobs which enabled them to contribute actively to the solutions of work-related problems. They also found that individuals who perceived that they received higher social support also reported lower emotional exhaustion scores. Staff who were more confident with their ability to cope with job change reported a higher readiness for organisational change, participated in a greater number of re-design activities in the following years, and felt they had made a greater contribution to organisational change at Time 2. In conclusion, they state:

“..this study suggests that active involvement in organisational change, reducing barriers to participation (e.g., shift-working), and building problem-solving strategies, and enhancing workers' perceptions of their ability to cope with change (self-efficacy), should both enhance commitment to re-design, and reduce the stress of organisational change” (Cunningham *et al.*, 2002, pp. 389-390).

### **Organisational climate, attitudes to work, and performance**

As with research on leadership, the attitudes to work that are most commonly assessed are different aspects of job satisfaction, motivation, and commitment. Bartram, Robertson and Callinan (2002) identified four kinds of organisational performance: economic; technological; commercial; social, with most research focusing on economic aspects (productivity, profitability, &c.) (Patterson, Warr & West (2004).

In a review of ten studies, Wilderom, Glunk and Maslowski (2000) reported that, although most of them had found some dimensions of organisational climate to be associated with organisational performance, different aspects of climate had emerged as important in different studies. Furthermore, since most studies involved a cross-sectional research design, it was difficult to ascribe causal relationships.

However, in the studies by Denison (1990) and by Gordon and DiTomaso (1992) organisational climate was assessed prior to obtaining objective performance data. Denison reported that, across 34 firms in 25 different countries, a climate that encouraged employee involvement in company decision-making predicted subsequent financial success, though this was not true for three other climate dimensions. Aspects of organisational adaptability

(a combination of 'action orientation' and 'risk taking') were found by Gordon and DiTomaso to be positively associated with subsequent financial success among 11 insurance companies; again, three other aspects of climate were unrelated.

As Patterson *et al.* (2004) point out, differences in the results may arise in part owing to differences in the organisations studied, and in part to the 'intervening processes' that may translate an organisation's climate into performance. Models of how these variables may operate have been proposed by Kopelman, Brief and Guzzo (1990) and Sparrow (2001). Kopelman *et al.* saw the influence of organisational climate on productivity as being mediated by "cognitive and affective states" (primarily work motivation and job satisfaction) and "salient organizational behaviours" (attachment behaviours, role-prescribed behaviours, and citizenship behaviours).

The model has been further developed by Sparrow, who additionally incorporates aspects of person-organisation fit and psychological contract. The psychological contract is seen to incorporate "mental, emotional and attitudinal states" and "salient organizational behaviours". The psychological states (which include perceived justice and organisational support; work motivation; feelings of trust, commitment, job involvement and job satisfaction) are seen to link perceived organisational climate and potential person-organisation fit with relevant employee behaviour and then performance at an organisational level. Unfortunately, there has been little empirical research to establish the validity of these models (Patterson *et al.*, 2004), though Meyer, Stanley, Herscovitch and Topolnytsky (2002) reported a tendency for work motivation, job satisfaction, job involvement, organisational commitment, and experience of justice and support to be positively inter-correlated; and it may transpire that their role in mediating between climate and performance is similar.

Following their extensive review of the literature, Parker *et al.* (2003) have speculated that the mediating influence of work attitudes and motivation in the relationship between psychological climate and organisational performance could be understood in terms of the following causal relationships shown in Figure 1.3.

The five climate categories were significantly inter-correlated ( $r = 0.295 - 0.328$ ), and each was significantly correlated with job satisfaction, work attitudes, psychological well-being, motivation and performance, but with different patterns of relationships between climate and the different outcomes. The weakest correlations involved job and role performance, while leadership, work group, and organisational performance were the strongest predictors of employees' work attitudes, with a similar patterns emerging for aspects of psychological climate with employee motivation and organisational performance. However, job and leader perceptions had the strongest relationships with psychological well-being. Overall, perceptions of psychological climate appear to emerge as having strongest links with staff attitudes than with employee motivation or organisational performance. Their results led them to conclude, consistently with the model (above), that the

effect of perceptions of climate is mediated by work attitudes and motivation. Subsequent analyses of the relationship between perceptions of climate, work attitudes, and motivation led to the proposal a revised model (Figure 1.3).

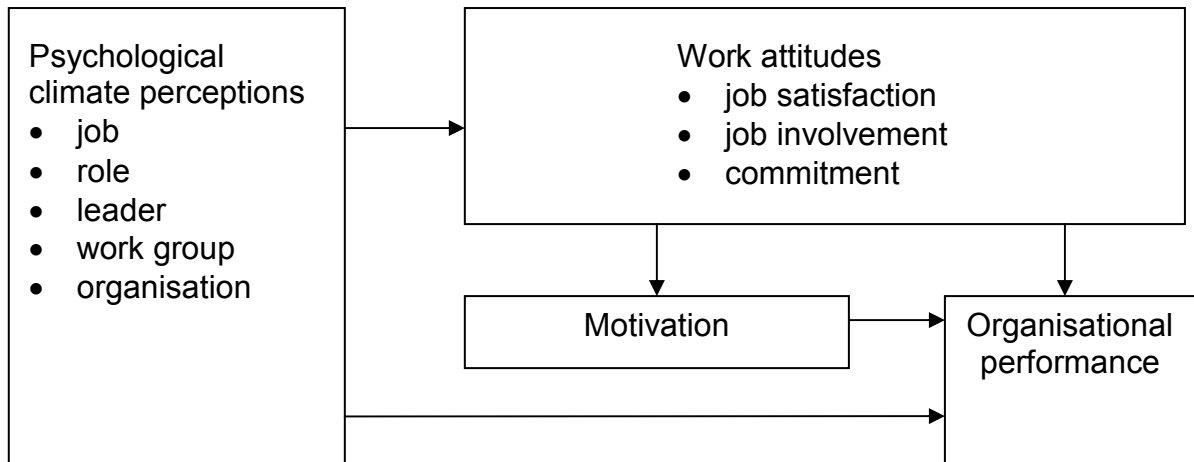


Figure 1.3 – Based on Parker *et al.* (2003)

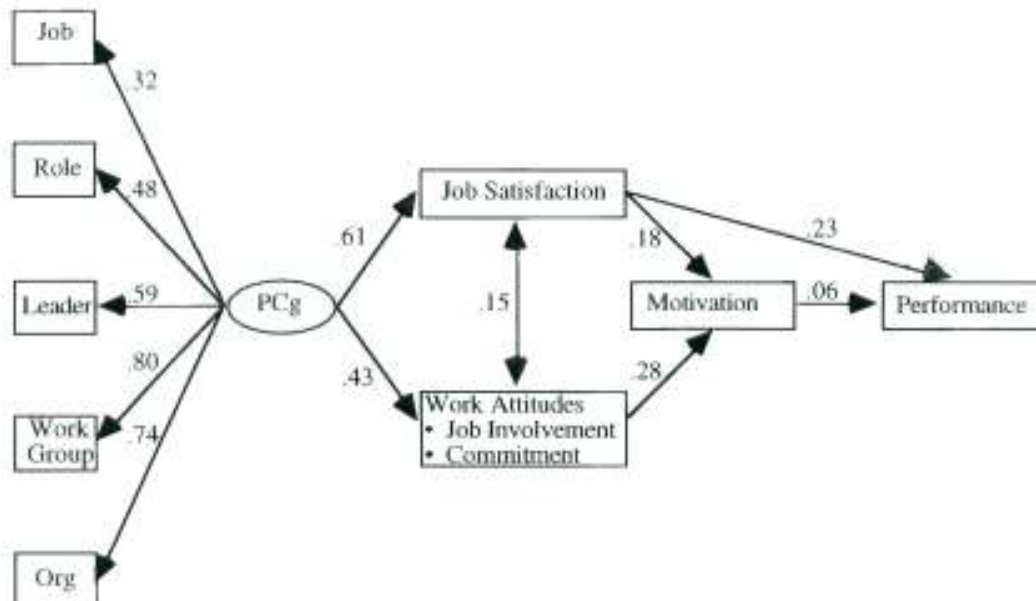


Figure 1.4 taken from Parker *et al.*, 2003.

The longitudinal investigation undertaken by Patterson *et al.* (2004) was among 42 UK manufacturing companies and involved a total of 4,503 employees. They examined relationships between 17 dimensions of perceived organisational climate, job satisfaction (16 item scale;  $\alpha = .92$ ) and organisational commitment (9 item scale;  $\alpha = .85$ ), organisational performance

(profitability and productivity), and contextual factors (job content; status; number of employees; industry sector).

Consistently with previous studies, job satisfaction and organisational commitment were highly inter-correlated across the 42 companies ( $r = .88$ ), and at an individual level ( $r = .72$ ,  $n = 3,894$ ). Findings involving these two aspects of attitude to work were reported as almost identical. Similarly, the indices of profitability and productivity were highly inter-correlated ( $r \geq .83$ ), though relationships involving profitability were less strong than for productivity.

Five aspects of organisational climate (concern for employee welfare; skills development; reflexivity and flexibility; performance feedback) were significantly correlated with subsequent productivity. After contextual factors had been controlled for, reflexivity and flexibility was not significantly correlated, but four additional dimensions (supervisory support; effort; quality; formalisation) were. Job satisfaction and organisational commitment were found to be significantly correlated with organisational performance ( $r = .44$ ,  $p < .01$ ;  $r = .36$ ,  $p < .05$ ), both before and after control for contextual factors.

Evidence that, using hierarchical multiple regression analyses, introduction of job satisfaction into the equation reduced the statistically significant relationship between organisational performance and each of the eight climate dimensions to a level of non-significance provided evidence that this work-related attitudes acts as a significant intervening factor. There was no evidence of differences in these relationships when separate calculations were undertaken for managers and non-managers.

Mannion, Davies and Marshall (2005) investigated the relationship between organisational culture and the star rating of six NHS Acute Trusts, categorised as either 'high' or 'low' performing, using a case study approach. Although the extent to which the leadership of the trust was engaging or 'post-heroic transactional' was not assessed, it was evident from the findings that the culture of the two 'high' performing trusts was consistent with the effect of a combination of competent leadership (referred to as 'transactional') with such a leadership style. Indeed, it was reported that, "There were a range of recent initiatives in both organisations to devolve power and responsibility down to individual directorates and nurture a more participatory and decentralised style of management" (p.436). The style of leadership within the high performing trusts can be seen to be engaging and distributed in that there was an integrated management structure with a corporate orientation, middle management was strong and empowered, lines of accountability were transparent, and there was proactive engagement with the local health economy. Not surprisingly, low performance was associated with a "charismatic" style of leadership, a "cabalesque" style of management, senior managers who were preoccupied with their own maintenance needs, and under-developed and emasculated middle managers, with the ultimate taboo being to challenge senior management; there was also high senior management turnover. The performance of the low performing trusts serves to illustrate aspects of the dark side of charisma.

## Leadership and organisational culture/climate

Psychologists in the field of leadership research have for a long time given their attention to the relationship between the leadership and the culture of organisations. Schein (1985) referred to the inextricable link between leadership and organisational culture, describing them as “two sides of the same coin”, and suggested that “the unique and essential function of leadership is the manipulation of the culture”, while Parker *et al.* (2003) concluded that leadership is one of the five dimensions of perceptual climate that emerged from their meta-analysis of the literature.

Schein’s view is supported by Bass and Avolio (1993) who see an inextricable link between leadership and organisational culture, stating “The organisation’s culture develops in large part from its leadership while the culture of an organisation can also affect the development of its leadership”. They maintain that the process by which leaders influence culture is by the creation and reinforcement of organisational norms and behaviour. Furthermore, in human resource terms, Bass (1998) maintains that recruitment, selection and placement decisions are all influenced by the prevalent values and norms.

He goes on to argue that the culture can be analysed in terms of the extent to which an organisation is transformational or transactional, and to point out that,

“The founders’ and successors’ leadership shape a culture of shared values and assumptions, guided and constrained by their personal beliefs. The organisation’s survival depends on how well those beliefs match up with the organization’s continuing opportunities” (1998, pp. 62-3).

Consistently with the view expressed by Schein (1985), Bass sees organisational culture and leadership as interacting with each other, with norms (which are significant in times of crisis, in providing role models, and inspiring others to become involved) developing in according to what leaders stress as being important. However, the culture of an organisation affects its leadership as much as leadership affects the culture; in the terms articulated by Schein, “leadership and organizational culture are two sides of the same coin”. Thus, as we shall see, the culture that a leader establishes may either enhance or limit their range of actions open to an organisation to perform.

At times when an organisation (or team or department) is becoming established, and at times of relative stability, a ‘strong’ (i.e., highly ‘normative’) organisational culture can be a source of strength. However, the extent to which a strong culture enables an organisation to be successful depends on external factors, particularly whether it enables the demands made on it to be met. This means that, in order to achieve success, having a strong culture may have to be balanced against being adaptable and responsive to change. Thus, when an organisation’s culture fits with demands on it, the organisation is likely to be effective. Conversely, when demands change (e.g., available personnel, the economy, government, markets, suppliers, technology), a

strong culture may be one that is unable to match the external changes (Bass, 1998). It follows that what is required is a strong organisational culture *balanced* by an appropriate level of adaptability and flexibility (cf. Pajunen, 2006, cited earlier).

According to Kotter & Hesketh (1992), “only cultures that can help organisations anticipate and adapt to ... change will be associated with superior performance over time” (1992, p. 44). The same authors talk about an “adaptive culture”, which can be equated to a ‘transformational culture’ (Avolio & Bass, 1991), and identified the assumptions underlying a culture that is adaptable as,

- that people are trustworthy and purposeful
- that complex problems can be delegated to the lowest level possible
- that mistakes can be the basis of doing a better job, rather than recrimination.

Transformational leaders were seen as those who

- articulate a strong vision and purpose to followers
- align their followers around the vision and empower them to take responsibility for achieving parts of the vision
- accept responsibility for their followers’ development, taking on a teaching role when necessary.

To this, Burns (1978) would add that a transformational organisational culture is characterised by

- a sense of purpose and feeling of family
- long term commitments
- mutual interests, a sense of shared fates and interdependence of leaders and followers,

with leaders

- serving as role models, mentors and coaches
- working to socialise new members into a transformational culture
- contributing to the development of shared norms that are adaptive and which change in response to changes in the external climate in which the organisation finds itself.

In an organisation which is moderately to highly transformational, there is likely to be a strong sense of belonging and mutual trust; values, vision and fulfilment, will be frequently discussed. Such an organisation is more likely to be innovative and to be able to adapt to changing circumstances, and to encourage empowerment and autonomy. Leaders who create or build such cultures are likely to have a strong sense of purpose, a clear vision, and take responsibility for developing and valuing staffs’ contributions, whilst encouraging questioning of the *status quo*.



In contrast to a transformational culture, Bass sees a transactional culture as one that concentrates: - on explicit and implicit contractual relationships, with job assignments accompanied by “conditions of employment, rules, regulations, benefits and disciplinary codes” (1998, p. 65); extrinsic motivation, based on the exchange principle of trade-offs between rewards for effort and avoidance of disciplinary action; commitments that are short-term, with self-interest being underscored; workers who work independently, and only cooperatively when self-interests are being served; discouragement of innovation and risk taking.

Organisations that are highly transactional, and also low in transformational characteristics, will be characterised by rules, regulations, rigid structure, explicit contracts, and controls. They are likely to foster self-interest at the expense of co-operation and collaboration amongst staff; goals are likely to be short-term, and staff likely to feel they have little opportunity to use their discretion and are more likely to feel controlled, and perhaps exploited. Individuals in a leadership position who create or reinforce such organisations, reflect the transactional behaviours of contingent rewards, or sanctions, in return for staff performance. Alternatively, they may adopt a management-by-exception style, and are likely to maintain organisational status quo, discouraging creative thinking and challenges to traditional ways of operating. Their staff will consequently feel disempowered, under-valued, and more stressed (Bass, 1998a).

Evidence gathered by Bass and co-workers indicates a transformational culture is more successful than a transactional one when measured in terms of organisational vision, information sharing, quality assurance, customer satisfaction, and working with others (Avolio & Bass, 1994).

It has long been recognised that the best predictor of an organisation’s culture, which includes the way people are treated (for example, whether they are empowered, encouraged to use their discretion; whether they are provided with opportunities to express their views; whether they are supported in implementing their ideas, suggestions, and problem-solving strategies, or not) is determined by the behaviours of those occupying senior management positions (e.g., Schein, 1985; Bass & Avolio, 1993). Schein has stated that the single most important responsibility of any manager is to create the appropriate organisational culture. This returns us to the nature and significance of leadership in affecting organisational culture/climate.

Many of the scales reported on by Patterson *et al.* (2004), such as ‘Concern for employee welfare’ and ‘Skill development’ can readily be identified with the Parker *et al.* (2003) ‘leadership’ dimension, though the latter has not been differentiated into its constituent elements.

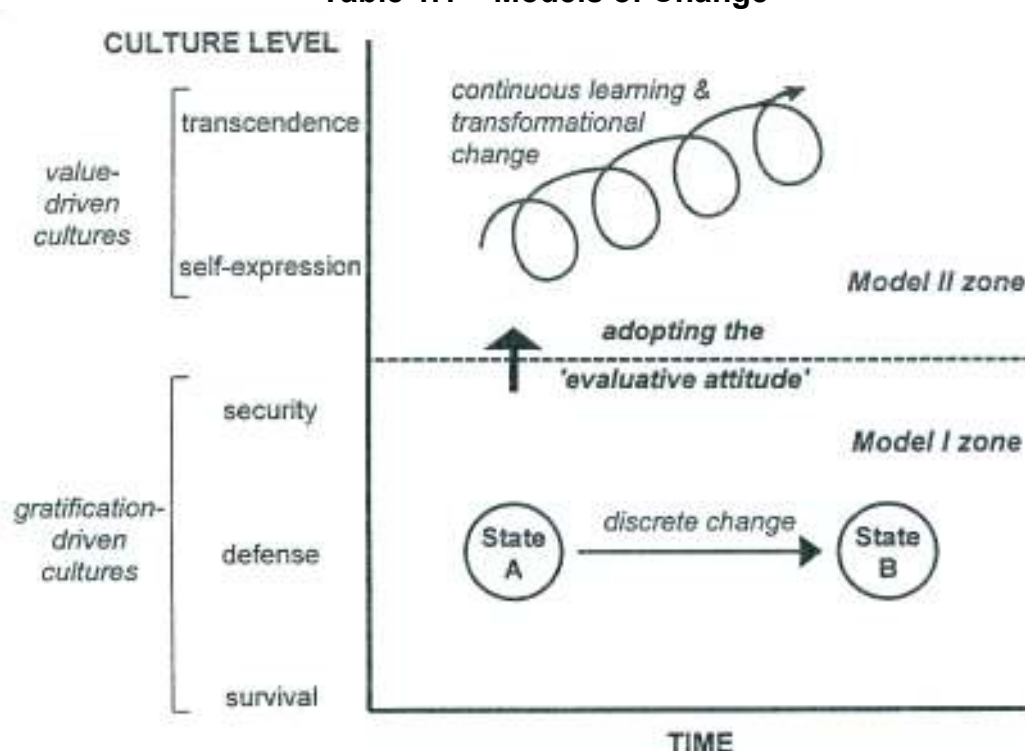
## The processes of culture change

It has been suggested that there is an *hierarchy* of organisational cultures (Harrison, 1995), and that the 'level' that an organisation occupies influences the kind of change that can take place (Sathe & Davidson, 2000). The first three levels: - 'survival' → 'defence' → 'security', collectively described as 'zone one' or 'gratification-driven cultures', are seen as needing first to solve operational problems, with an emphasis on increasing efficiency. The subsequent levels – 'self expression' → 'transcendence' – are described as 'zone two' or 'value-driven cultures', and can be seen to correspond to Bass's 'transformational' culture (Bass, 1998; Sathe & Davidson, 2000).

Following this line of thinking, an approach to effecting culture change that corresponds to Argyris' Model I learning is most appropriate for organisations at the first three levels (Argyris, 1993). This can be characterised as involving 'unfreezing' → 'moving' → 'freezing', which is a linear process (Table 1.1).

In contrast, it is suggested that 'iterative' or cyclical, 'double loop' processes (Argyris Model II learning) are most appropriate for organisations at levels four or five.

**Table 1.1 – Models of Change<sup>9</sup>**



### *Unfreezing-Moving-Freezing*

This approach is based on the analyses of Kurt Levin, who devised the technique known as 'Field-Force Analysis', is one of the ways commonly used for analysing change management processes (Iles & Sutherland, 2000).

<sup>9</sup> Based on Sathe & Davidson (2000).

*Unfreezing* is the process of reducing the forces that maintain the *status quo*, and can be achieved by confronting individuals with the contrast between their beliefs and reality, or between their actual and espoused values, by pointing to (or deliberately creating) perceived crises or threats. As such, it is a technique for bringing about some sort of encounter with, what for the participants may be, a surprising reality. At a strategic level, the decision has to be taken as to whether to target,

- the current behaviour or mindset of the participants, in other words to begin the question the appropriateness of their actions, or their interpretations of events; or
- pre-existing behaviours and attitudes that need to be confronted or substituted. This approach, which characteristically involves some kind of confrontation, is largely untested.

*Moving* involves increasing the forces that favour change, by pushing attitudes, values, and/or behaviours to a new level. Here, two techniques are used,

- encouraging those involved in the process to come up with their own redefinition of events. This technique is adopted by those practitioners with strong orientation to organisational development, with its traditional humanistic emphasis on facilitation and consensus building;
- more deliberate attempts to redefine beliefs and values in a certain way. These are used to achieve a more macro-level, strategic view of the kind of change that is required. Those advocating their use prefer to leave less to chance, and emphasise the need for a more deliberate push toward the creation of more specific beliefs and values, deemed essential for the success of the new strategy.

As with the unfreezing process, the issue is whether to concentrate on changing minds or behaviours. The majority of writers favour interventions that,

- have a strongly cognitive focus, aimed at forging a redefinition of beliefs and values, in other words, changing people's minds, rather than behaviours, at least initially;
- involve the use of a group settings, aimed at achieving consensus.

*Freezing* aims at the institutionalisation of the new equilibrium, what Levin described as "reconstruction of the social field". Here, there are two approaches those with: -

- an emphasis on natural processes, by which new beliefs and values become 'second nature';
- a focus on structural and procedural levers that can be used to institutionalise the new culture.

Some find it more fruitful to focus on 'mind shift', with an emphasis on intrinsic motivation, whereas others focus on 'behaviour shift', and on extrinsic

motivation. In both cases, the question arises as to what, if anything, can or should be frozen.

### *Double-Loop Processes*

A key feature of more advanced organisational cultures appears to be their ability to learn effectively, involving processes that can be described with reference to Argyris' Model II learning which promotes continual change through 'double-loop' learning. This can be summarised as: -

analysis of existing situation → innovative thinking → formulation of a plan → implementation → evaluation → analysis of resulting (new) situation → formulation of modified plan, and so on;

in other words, there is a continuous and continuing process of learning, based on critical evaluation.

Another key feature of such organisations is tolerance for mistakes. As Vollman (1996) observed, "If change proceeds with no failures, the speed of change is probably too slow" (p. 243), while others have written of creating a "climate of continuous change" through experimentation and openness to "learning about the positive and negative effects of particular practices" (Lawler, 1996, p. 254).

Empirical support for piloting innovation and tolerance of mistakes comes from a large study sponsored by Shell in 1983, which found that long-lived companies were both sensitive to changes in their environment and tolerant of "outliers, experiments and eccentricities ... which kept stretching their understanding of possibilities" (de Geus, 1997, p.7). There were also warnings against an exclusive focus on financial indicators which, being based on previous performance, are essentially backward-looking. Rather, a 'balanced scorecard' approach was advocated, which advocates checking links between financial outcomes and 'softer' intermediate variables, such as culture, competence, and process capability, i.e., different aspects of organisational culture and organisational capabilities.

Thus, Model II or 'zone two' organisations are seen to have strongly 'values-driven' cultures, which allow open debate about what is right and wrong, good and bad. According to Sathe and Davidson (2000), self-expression and transcendence level cultures differ in "the extent of agreement on the values against which results and actions are evaluated" (pp.292-3). What characterises the transition from the Model I to the Model II zone is a switch to the values of learning organisation, which can be achieved most effectively by adopting an 'evaluative attitude'.

Here, it is important to distinguish between,

- management informational systems activity which has, as its focus, the achievement of goals and targets, which are confined to existing frameworks; and

- activities focused on determining merit, worth and significance, which involve the use of 'out-of-the-box' thinking.

### *Four Quadrant Analysis*

An alternative approach to analysing change is in terms of two orthogonal dimensions: -

- change as a predictable phenomenon—change as a complex phenomenon
- uniform approach to change—disseminated and differentiated approach (Higgs & Rowland, 2005).

This would lead to the identification of four kinds of change (™RFLC, 2003, cited in Higgs & Rowland, 2005) (Figure 1.5).

Following their analyses, Higgs and Rowland suggested that two further dimensions can usefully be distinguished. These are:

- systematic versus opportunistic – system-wide and planned versus responsive to opportunities
- high control versus low control – extent to which the change is controlled and directed on a top-down basis.

**Figure 1.6 – Four kinds of change**

<p style="text-align: center;"><b>'Directive' change</b></p> <ul style="list-style-type: none"> <li>• simple, with a predictable outcome</li> <li>• driven and managed from 'on top'</li> <li>• uses a simple theoretical model</li> <li>• involves a small range of interventions</li> <li>• has few targets</li> <li>• involves explicit management</li> <li>• is controlled through objectives and timescales</li> </ul>	<p style="text-align: center;"><b>Sophisticated or 'master' change</b></p> <ul style="list-style-type: none"> <li>• complex, with unpredictable outcome</li> <li>• driven and managed from top or centre person or small group</li> <li>• uses a complex theory of change</li> <li>• involves a wide range of interventions</li> <li>• extensive engagement which influences change process</li> <li>• explicit project management</li> </ul>
<p style="text-align: center;"><b>DIY or 'Self assembly' change</b></p> <ul style="list-style-type: none"> <li>• direction set tightly</li> <li>• local accountability</li> <li>• encourages building of capability &amp; capacity</li> <li>• sets strategic direction, with local adaptability</li> <li>• uses existing templates for action</li> </ul>	<p style="text-align: center;"><b>'Emergent' change</b></p> <ul style="list-style-type: none"> <li>• loosely set direction &amp; few big rules</li> <li>• initiated anywhere in the organisation, typically where there is client/ customer contact</li> <li>• emphasis on sharing best practice</li> <li>• emphasis on lateral connections</li> <li>• novel mix of participants</li> </ul>

### **Issues in Culture Change**

In setting out to achieve culture change, three important issues need to be addressed (Sathe & Davidson, 2000). These are concerned with: - changing

underlying assumptions and beliefs; intrinsic *versus* extrinsic motivators; the timing and sequence of motivators.

### *Underlying assumptions and beliefs*

Schein (1985) argues that some of the more superficial values and beliefs can be changed, but that the deepest of the organisation's underlying assumptions cannot be confronted or debated. Such confrontation or debate would challenge the fundamental nature of the organisation. According to Argyris, an organisation's defensive routines are un-discussable, as is the 'un-discussability' itself (Argyris, 1993).

Argyris supports the practice of comparing espoused values with those values that are implicit in actions and words, i.e., observed values, as a way of stimulating change. In this way, taken-for-granted beliefs and values can be brought to the surface and addressed openly – a mechanism that Sathe regards as a key mechanism for culture change. In contrast to Schein's view, there is empirical support for Sathe's belief that "the deepest level of culture (beliefs and values) *can* be brought into consciousness, challenged and changed" (Sathe & Davidson, 2000, p.283).

### *Intrinsic versus extrinsic motivators*

Extrinsic motivation is the result of the actions that are prompted by another person, and the target of extrinsic motivators is to bring about changes in behaviour. In contrast, intrinsic motivation comes from within an individual, who acts in a certain way because this way is consistent with their values and beliefs. It follows that the success of any attempt to effect any kind of change will depend on stimulating an individual to reflect critically on what they believe and what they value.

The general consensus is that sustained culture change requires changing people's minds as well as their behaviour (Sathe & Davidson (2000)). It does not follow from this, however, that both kinds of motivator – extrinsic and intrinsic – are necessary. If they are, however, two questions follow: -

- Which should be given greater emphasis – extrinsic or intrinsic?
- Is it more effective first to change people's minds, such that their behaviour will change, or *vice versa*?

Most writers favour the use of intrinsic over extrinsic motivators, though the empirical evidence suggests that both can be effective, depending on the circumstances. Reasons for advocating the former include: -

- that use of intrinsic motivators tends to be non-coercive;
- that a change in belief systems is necessary to achieve sustainable behavioural change;
- that extrinsic motivators tend to produce "surface compliance and covert rebellion" (Harrison, 1995, p. 159);

- that use of intrinsic motivators favours proactive, purposeful, goal-directed behaviour, whereas extrinsic motivators result in reactive behaviour (Litwin, *et al.* (1996);
- that intrinsic motivation for change is generated by encouraging dissatisfaction from within with the status quo (Sathe & Davidson, 2000).

The nature of extrinsic motivators, and the context in which they are applied, can affect their effectiveness. Thus,

- a top-down organisational change strategy was implemented in two large organisations. In Organisation A, the potential problems were communicated, but the individual units were left to decide what changes to implement (intrinsic motivator); in Organisation B, a large number of detailed change initiatives were imposed (extrinsic motivator). The former approach led to success by developing a culture of urgency, whereas the latter resulted in “fear, resignation, [and] sham compliance” (Vollman, 1996, p. 237);
- a large retail organisation closely monitored at a behavioural level the successful implementation of a detailed organisational change programme (external motivator). However, healthy competition among the retail stores on their ‘behavioural scorecard’ engendered internal motivation among staff (Binder, 1998);
- extrinsic motivators can perform a symbolic role. For example, Nadler and associates reported that rewards are “what employees most frequently mention as the real indicator of commitment to cultural values” (Nadler *et al.*, 1994, p. 162);
- the nature of a reward is a key determinant of its effectiveness. Thus, a number of studies have shown that managers who emphasise recognition and encouragement were more successful in achieving target results than those who relied heavily on financial incentives (Litwin *et al.*, 1996);
- organisations which rely exclusively on compensation as a means of recognition tend to lose the power to innovate (Hurst, 1995).

As Sathe and Davidson point out, the use of external motivators simple to induce behavioural change is advocated by only a few writers (Sathe & Davidson, 2000). Rather, the emphasis is on the use of,

- intangible rewards and punishments to increase intrinsic motivation;
- external motivators as symbols to reinforce and to help institutionalise desired beliefs and values;
- external motivators, in the form of negative information about its performance, to shock an organisation into unfreezing.

When used in this third way, the energy needed for moving and organisation into ‘zone two’, the ‘transformation zone’, can be generated by confronting it with reality Miles (1997), for example, by presenting ‘benchmarking’ data (Wind & Main, 1998).

#### *Timing and sequence*

Finally, there is consensus that, while both extrinsic and intrinsic motivators have a role to play in bringing about culture change, the latter are superior. Also, most writers suggest that they should be used first, or in parallel with extrinsic motivators, not the other way round.

Thus, it is suggested that intrinsic motivators be used to establish the need for change, first among 'change agents', then among 'bystanders', and lastly among 'traditionalists'. However, it is also suggested that extrinsic motivators be used first with those who actively resist change (Strebel, 1999). In addition, extrinsic motivators can also be used to institutionalise the change once it has been established, while the option to leave, voluntarily or otherwise, exists as a last resort for those who are unwilling to embrace the proposed change (Sathe & Davidson, 2000).

### **Leadership and the Change Process**

On the basis of qualitative and quantitative analyses of 70 change stories, Higgs and Rowland identified three leadership styles: -

- Shaping behaviours (what leaders say and do; making others accountable; thinking about change; using an individual focus)
- Framing behaviours (establishing 'starting points' for change; designing and managing the change journey)
- Creating capacity (creating individual and organisational capabilities; communicating and creating connections) (Higgs & Rowland, 2005).

Overall, 'shaping behaviours' were found to be counter-productive in achieving successful change, while 'creating capacity' tended to be associated with success, but clearly, contextual factors are likely to be relevant.

Table 1.2 shows the relationship between leadership style and success and the approach to change adopted in different contexts. The same authors also found evidence that 'shaping behaviours' are dominant when the change is 'directive'; that 'framing behaviours' are dominant when the change involves either a 'master' or 'DIY' approach; and 'creating capacity' behaviours dominant when the approach to change is 'emergent'.



**Table 1.2 – Relationship between leadership behaviour and approach to change encountered in different contexts**

<b>Leadership Behaviour</b>	<b>Context</b>
<ul style="list-style-type: none"> <li>• Shaping behaviour</li> <li>• Framing behaviour</li> <li>• Creating capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Low-scope, low-magnitude and internally driven, which could be local leader-led</li> <li>• Short time scale, high-scope, high-magnitude and externally driven</li> <li>• Where there is a long history of change, long-term and internally-driven</li> </ul>
<b>Type of change</b>	<b>Context</b>
<ul style="list-style-type: none"> <li>• Directive change</li> <li>• Master change</li> <li>• DIY change</li> <li>• Emergent change</li> </ul>	<ul style="list-style-type: none"> <li>• Relatively short history of change; this is the most common model</li> <li>• Complex, externally-driven</li> <li>• Independent of context</li> <li>• Long-term, internally driven</li> </ul>

With regard to the success of the change process, the leadership behaviours of

- shaping were negatively related to success in most contexts;
- framing were positively related to success in high-scope, high-magnitude, short-term, individually-led contexts, though inappropriate for internally-driven, long-term change in organisations with a long history of change;
- creating capacity appear to be related to success in contexts involving internally-driven, high-scope, low-magnitude and long-term change,

while,

- a directive approach appears unrelated to success in any context;
- master approaches are successful in programmes involving low-scope and long-term change programmes;
- DIY change appears negatively related to success in all contexts;
- emergent change appears particularly important where there is high-magnitude change.

What is evident is that the leadership styles of ‘framing’ and ‘creating capacity’ are essentially transformational in nature.

What emerges so far is that useful distinctions can be made between different organisational ‘levels’, and different approaches to bringing about change, together with some understanding of different kinds of ‘motivators’.

The significance of choice of leadership style for achieving successful change is evident, as is the importance of achieving a good 'leadership style-approach to change-context' fit. For reasons adumbrated earlier, effective leadership requires 'distributed' style of leadership, whereby those in a leadership role perform that role competently, in an engaging way.

Having reviewed the main literature on leadership and organisational climate and change management, we turn to the context in which leadership will be examined for the purposes of this study, and review the literature on the development of crisis resolution teams and their national implementation.

## **SECTION 2 – DEVELOPMENT OF CRISIS RESOLUTION/HOME TREATMENT TEAMS – FROM CONCEPTION TO THE PRESENT**

The growth of crisis resolution or home treatment teams came out of the general changes in practices during the shift towards community oriented mental health care. Originally crisis teams were not distinct services whose main purpose was to manage crises and prevent admission to hospital. This emerged much later where specialist crisis teams were formed with their own staff base and budget.

### **Dealing with a crisis – nature and definition**

What constitutes a 'crisis' continues to be relevant as it did two decades ago with the advent of community care and the deinstitutionalisation of the mentally ill. One influential definition was postulated by Caplan (1964) who conceptualised a 'crisis' based on an individual's ability to use problem-solving abilities to deal with psychosocial stress. Situations which presented a challenge to an individual, where they were unable to draw on their usual coping mechanisms, would result in a crisis reaction. Caplan viewed this crisis reaction as a 'normal' rather than pathological response to a harmful event and could relate to anyone with or without a diagnosed mental illness. This crisis reaction was seen as a 'transition' from which an individual either experiences psychiatric impairment or emotional growth. This introduced the notion that a crisis was time limited, usually between four to six weeks (Caplan 1964).

Psychosocial crisis has been differentiated from psychiatric emergencies (Rosen, 1997). The latter is often defined in terms of an immediate need for action where there is a strong element of risk or is 'life threatening'. Significant risk tends to feature in other definitions of an emergency which requires professional intervention, particularly in the context of psychiatry (Katschnig & Konieczna, 1990).

The distinction between crisis and emergency is not as clear cut in clinical practice. Individuals experiencing Caplan's definition of a crisis and without a previously diagnosed mental health problem, seldom present to services (Katschnig, Konieczna & Cooper, 1993). Yet individuals who do find difficulty in adjusting to psychosocial stresses can invariably lead to the build up of situations often seen in psychiatric emergencies in people with severe mental illness (Jones & Polak, 1968).

Recent discussions of crises tend to use the term in a more pragmatic sense, with more tightly defined boundaries to include an urgent need for professional intervention and where there is an increased risk associated with it (Brimblecombe, 2001). Modern crisis services, including CRTs, have adopted this definition where the main goal is to prevent or divert individuals from admission to hospital (Johnson & Graham 2007). These modern crisis

services have evolved significantly since the beginnings of community based alternatives to hospital admission.

### **Early pioneers of CRTs and innovations**

Early pioneers of alternatives to hospital developed models of community-based treatment for people with severe mental health problems in crisis. In the USA these new initiatives demonstrated the feasibility and effectiveness of treating people in their own homes (Stein & Test, 1980; Fenton *et al*, 1979; Polak & Kirby 1976; Pasaminick, Scarpetti & Dinitz, 1967).

A prominent example of one early initiative, Training in Community Living (TCL), developed in Madison, Wisconsin involved intensive contact with patients in the community. Included within the TCL model was assistance with social and practical issues (Stein & Test 1980). During a crisis, intensive treatment was delivered and then continued even after the crisis was resolved. This ensured improvement in social functioning and stability in the community. The piloting of this approach started with selecting inpatients to receive intensive treatment and support in the community. This subsequently led to recruiting patients on referral to hospital for admission. The availability of staff 24 hours a day was initiated in which to support patients with a variety of daily living activities ranging from practical tasks to seeking work.

In 1979, Hoult replicated the TCL model in Sydney following visits to the USA and the UK (Hoult, 1986). The community service introduced here comprised of crisis management and family work based on an approach used in Barnet (Scott & Seccombe 1976), and the Madison model of continued care after a crisis.

These early community initiatives are often described as the origins of crisis resolution and assertive outreach services, and although they bare some similarity they were not precursors of them (Johnson & Thornicroft, 2007).

A successor of the TCL model better reflects the key components of crisis resolution teams. In 1974, Leonard Stein, following a move to Dane County, set up a comprehensive network of community services in an effort to reduce the reliance on expensive acute inpatient beds (Stein, 1991). This was dealt with by instigating a specialist crisis resolution and stabilisation service. Its purpose was to carry out rapid assessments of all referrals to hospital and provide intensive treatment in the community for a short period of time. The service provided 24 hour coverage for assessment, to facilitate early discharge from hospital and carry out multiple visits per day if necessary (cited in Johnson & Thornicroft, 2007). This service continues to operate 24 hours a day to assess patients requiring a hospital admission, facilitate early discharge and provide intensive community support. Patients are discharged to other services once their crisis has been resolved.

In Sydney the development of specialist CRTs was initially introduced via an integrated approach within a Community Mental Health Team (CMHT). The service provided assessment and intensive home treatment. Attempts were

made to introduce specialist CRTs in New South Wales (NSW) but support from the government was withdrawn in 1988. Crisis teams operate in parts of NSW although their configurations, capacities and resources vary considerably. Provision of 24 hours services has been reduced by some teams and others have based themselves in accident and emergency departments. In Victoria efforts have been made to encourage the adoption of crisis assessment and treatment teams (CATTs). These services are similar to the CRT model in England and operate 24 hours a day, seeing adults of working age during office hours and the entire population out of hours (Carroll *et al.*, 2001).

In 1970, the Barnet psychiatric service in London introduced a specialist team devoted to preventing admission to hospital and providing treatment in the community (Scott, 1980). The purpose of this service was to understand the basis of the crisis by exploring family processes and make attempts at resolving it. The service was available 9am to 5pm and if admission to hospital was deemed appropriate visits by the team took place once a week only and continued in the long-term in an outpatient clinic. Resistance to this service was evidenced by local opposition and questions were raised about the safety of this practice (Johnson & Thornicroft 2007).

By the 1990s, community mental health teams (CMHTs) were the main providers of emergency intervention. CMHTs were limited in what they could do when dealing with an acute crisis, partly because they functioned only during office hours. In some areas of England the development of other models to manage emergencies in the community more effectively began to emerge. Towards the end of the 1980s and early 1990s two home treatment programmes were introduced in Birmingham. The first was targeted at the needs of the Asian community and offered an integrated service with continuing care (Dean, Phillips, Gadd, Joseph & England, 1993), but was short lived; and a second was introduced to meet the needs of young African Caribbeans. However, the introduction of the Yardley Psychiatric Emergency Team in 1995 headed by John Hault established a model that formed the backbone of modern community crisis services, and later underpinned government policy and the national implementation of home treatment teams (Glover & Johnson 2007).

## **National policy on crisis services**

### *Policy implementation guidelines*

Several factors contributed to the development of a national policy to improve the management of psychiatric crises. The aim of which was to avoid the use of psychiatric inpatient beds. These influencing factors started with a slight increase in admissions to hospital in the mid 1990s, with a more notable rise in compulsory admissions (Szmukler & Holloway, 2001). A second factor related to a growing discontent among service users concerning the quality of therapeutic care and the physical environment of inpatient wards. Other issues also concerned patient safety, the lack of meaningful activities and

limited contact between patients and staff on inpatient wards (Quirk & Lelliott, 2001; Rose, 2001). All these factors led to what was regarded as 'crisis in acute care' (Appleby, 2003).

The National Service Framework for Mental Health (DH 1999) set out the beginnings of a new policy on crisis services. This policy stated that local services must provide 24-hour access to emergency assessment and offer home treatment as an alternative option to admission to hospital. Publication of the NHS Plan (DH 2000) specified a target of developing 335 crisis teams in which each team would aim to see approximately 300 people a year. The NHS Plan also suggested CRHTs could relieve the pressure on acute psychiatric beds by 30%. The way teams were to be organised was not detailed until 2001 with the Policy Implementation Guide for Crisis Resolution Teams (DH, 2001c). This policy outlined what CRHTs should provide and included:

- assessment - to ensure the service was appropriate for the individual referred,
- planning - to produce a focused care plan and decide the number of visits,
- intervention - by a designated worker, intensive support through frequent visits, medication, help with daily living activities and family/carer support, therapies, relapse prevention and crisis planning, respite and links with inpatient services, and
- resolution - discharge planning and identification of services for transfer.

This was by no means a linear process, and at anyone one point of a service user's care, all four stages can be active. Each stage is also inter-dependent and if, for example, the assessment was inaccurate this would render the planning and invention stages ineffective (McGlynn & Flowers, 2006).

Teams were to have a caseload size of between 20 to 30 service users at any one time, and to cover a catchment area population of approximately 150,000. Suggestions were made for staffing levels and skill mix (including specialist skills) for each team in order to deliver the interventions. This included a total of 14 people per team comprising of a Team Leader, Community Psychiatric Nurses, Approved Social Workers (ASWs), occupational therapists, psychologists and support workers. Access to senior psychiatrists anytime of the day or night for home visits was considered crucial. Teams were to operate 24 hours a day, 7 days a week, 365 days a year.

A vital role for CRTs is to act as 'gate-keeper' to mental health services. This means assessing people with acute mental health problems rapidly and referring them to the most appropriate service, whether an acute inpatient ward, the CRHT itself, or other community mental health services. Reducing the pressure on acute inpatient beds is only really effective if CRTs have the right to gate-keep by assessing most, if not all, referrals for hospital admission (Hoult, 2006). The issues of gate-keeping has created significant tension between teams and professional groups (Hoult, 2006), but represents one of the single most important role for CRTs.

The service is intended primarily for people with severe mental health problems experiencing an acute crisis, essentially those that would otherwise be admitted to hospital (McGlynn & Flowers, 2006). These were service users with an existing diagnosis of, for example, schizophrenia, bipolar disorder or severe depression. The Mental Health Policy Implementation Guidelines (MHPIG) stated that CRHT were not to include people with mild anxiety disorder, a primary diagnosis of alcohol or other substance misuse, a primary diagnosis of personality disorder, a recent history of self harm without a diagnosis of psychosis, and crises that could be attributable to relationship issues. However, as Onyett *et al.* (2006) point out, these exclusion criteria are difficult to apply to a service that operates out of hours and for people in crisis.

At the time policy introduced CRTs, direct evidence underpinning its efficacy or effectiveness was limited. Regardless of this, the government pressed on with implementing its target of establishing 355 crisis teams across England.

### *Reactions to the implementation of CRTs*

The response to the new policy on CRTs was mixed. A survey of Chief executives of mental health trusts by Owens, Sashidharan and Lyse (2000) assessed the levels of access to home treatment, what plans were in place to introduce these services and gauge the attitudes and views of them. In 1998, 16% of 229 mental health trusts offered intensive home treatment. Despite this low percentage, 97% of trusts expressed a keen interest, with plans to develop, put in place or purchase home treatment services. Fifteen percent of trusts were not intending to provide these services and two reasons accounted for this refusal: clinical resistance and the lack of financial resources (Owens *et al.* 2000).

Smyth and Hoult (2000) raised the issue of why home treatment for acute mental illness was being ignored as an alternative to hospitalisation. Smyth and Hoult (2000) reiterate the early successes of home treatment and address some of the main criticisms aimed at it, such as burnout among staff, homicide and suicide, and its generalisability and sustainability. They conclude that the resistance was largely due to the rapid advancement of community care: the great reduction in psychiatric bed numbers, unfortunate events associated with it, and so explaining the defensive approach adopted by psychiatry.

Critics of CRHT point to two key issues – prevention of an acute crisis, particularly for individuals known to community mental health services, and continuity of care once a crisis is resolved. Pelosi and Jackson (2000) argue that the most important flaw in the Smyth and Hoult home treatment model in the UK concerns continuity of care. The model ignores the role played by primary care practitioners, and the gate-keeping function of General Practitioners (GPs) who refer to secondary services, where necessary, or perform many of the tasks considered part of the home treatment service model, such as practical assistance, counselling, medication and so forth. In addition to this, Pelosi and Jackson (2000) emphasise that community mental health teams provide long term assistance to those with major mental health

problems. Key workers of people with long-term conditions would be reluctant to transfer care to another community team in the event of a crisis or relapse of illness. These authors stress the contentious issue of diversion of resources from existing services to fund new specialist ones.

With the introduction of specialist teams, such as CRTs, changes in the role of adult general psychiatrists were implicated and brought to the fore for debate. A survey of 101 general consultant adult psychiatrists sought their views of crisis resolution teams, assertive outreach and early intervention services (Harrison & Traill 2004). Consultants were divided about whether they should specialise either in terms of treatment setting (whether inpatient or home treatment) or by clinical diagnostic grouping (affective disorders, psychotic illness, etc.).

### *Growth and profile of crisis teams: Mapping CRTs*

The Durham service mapping exercise conducted between 2000 and 2006 (Glover & Johnson 2007) tracked the progress of crisis teams as part of a monitoring system set up by the Department of Health. The largest expansion of crisis teams occurred between 2003 to January 2006, where the number of teams rose from 121 to 262 (Glover & Johnson 2007).

Reaching the government's pre-set target of 335 crisis teams became a leading political issue, the monitoring of which was deemed highly important. The Department of Health developed 'flexibility' arrangements to account for the variations on the model of crisis team being adopted by many trusts to decide if they had met their target or not. Crisis teams had to employ the number of staff outlined in the MHPIG (up to 14 per standard team) and deliver the same types of care. Up to half of mental health trusts succeeded in having larger teams acknowledged as more than one standard team – indicating a clear tendency towards larger teams than was originally foreseen (Glover & Johnson 2007). Ten Local Implementation Teams (LITs) were able to have CMHTs considered providers of CRT care. This together with the 262 teams, noted above resulted in an equivalent of 343 standard teams (Glover & Johnson 2007). Only three LITs did not provide crisis teams.

By 2006, 97% of crisis teams were available 24 hours a day, although what exactly constituted 24 hour cover was unclear. For example, whether a CRT was fully operational and staff were office based throughout, or instead were on call from home for emergency situations only (Glover & Johnson 2007).

Staffing levels reached full capacity (10 or more staff per team) for 90% of crisis teams in 2006. The median number of staff per team was 6.9 in 2000 which rose considerably by 2006 to 16.6. The mental health workforce employed to staff crisis teams reached 5,000 in 2006, though its impact on reducing the numbers of staff from other mental health services is unknown (Glover & Johnson 2007). Teams were predominantly multidisciplinary, with nurses making up the bulk of the team's composition. Interestingly, the percent of nurses dropped from 76.4% in 2000 to 59.0% in 2006. During the same period there was a considerable rise in the proportion of 'other clinical



staff' or support workers from 3.2% to 12.7%. The proportion of doctors also increased significantly by 4.2% during the same period.

### *Fidelity to the CRT model*

Fidelity to the model has been a consistent theme throughout the course of CRHT development and implementation. Again, the Durham mapping exercise revealed the proportion of crisis teams meeting five additional fidelity characteristics outlined in the MHPIG, namely – multidisciplinary; staff in frequent contact with services users; provision of intensive contact over a short period of time; involvement until the crisis is resolved; and capacity to offer intensive support in the person's home. These were over and above two core elements of CRTs operating 24-hours/7 days a week and gate-keeping admissions. By 2006 all crisis teams had each characteristic, except for the final one which was evident in 97% of teams. This reflects a strong adherence to the original CRT model in the past year. However, this was not the case in 2003 (Glover & Johnson 2007).

### *Current status of implementation*

Apart from the Durham mapping of CRTs, few nationwide studies have assessed their development and implementation status detail. A recent survey by Onyett *et al.* (2006) examined the extent of CRHT implementation, and unlike the Durham mapping exercise, gathered information directly from individual teams through telephone interviews primarily with team leaders. The survey provides a comprehensive assessment and description of many key structural, operational and process issues, together with issues in implementation and delivery including:

- Numbers of teams and their locations
- Overall progress on implementation as outlined by the policy guidance
- Team caseload size
- Staffing numbers and skill mix
- Input and role of psychiatrists
- Gate-keeping and out of hours provision
- Assessment and home treatment
- Interventions delivered
- Working with external agencies
- Management of teams
- Obstacles to implementation, and
- Actions and resources for development

243 CRTs were identified by the survey. Of the teams surveyed, only 40% considered themselves fully set up, largely because of a shortfall in staffing levels. The mean caseload size at any one time was 20, which was at the bottom end of the recommended range. 53% of participating CRTs, many of whom were based in urban areas, operated a 24/7 home visiting service. Those teams unable to provide this coverage again attributed it to lack of staff.

The knock on effect was that these teams found it difficult to meet the demand for their services.

Nearly all teams aspired to delivering an alternative to hospital admission for those experiencing acute mental health problems. However, there was a discrepancy between what teams aimed to do and what happened in practice. Only 68% of teams acted as gate-keepers to acute inpatient beds by assessing all those eligible for hospital admission. This difficulty was further exacerbated by the lack of a functionalised consultant psychiatrist role in some 60% of CRTs.

Onyett *et al.* (2006) also discuss the lack of fidelity to the MHPIG among rural CRTs and why it is difficult to achieve this. They argue that for these teams out of hours cover may not be entirely necessary for local stakeholders, and different types of implementation may be more appropriate.

### *Impact and effectiveness of CRTs*

Recent evidence published on the effectiveness of CRTs includes a Cochrane systematic review conducted by Joy *et al.* (2001, updated 2006). The authors included five randomised controlled trials on crisis intervention for people with serious mental illness. However, none of the crisis interventions reviewed functioned according to the original crisis resolution model. These interventions were adaptations or variations of crisis resolution services. There was a limited effect on admissions to hospitals, a reduction in family burden and was considered a more appropriate form of care for service users and families. There were, however, no differences in mental health outcomes, but crisis intervention was found to be more cost effective than inpatient care. The success of the service was dependent on how well it was implemented. If the service was poorly delivered the effects were likely to be detrimental to the service user and increase their admission to hospital (Ford and Kwakwa, 1996).

In another systematic review Burns *et al.* (2001) examined the effectiveness of home treatment looking also at admissions to hospital and cost-effectiveness. Of 91 studies identified 22 were included in the review. The authors found that the core function of services included was fairly homogenous, but varied in terms of team composition, having an integrated psychiatrist, caseload size, conducting home visits and taking responsibility for both health and social care. Impact on admissions was not found to be as high as other relatively new community based services.

Johnson *et al.* (2005) conducted a randomised trial of acute care delivered by a CRT in north London. The main outcomes examined were hospital admission and patients' satisfaction. The service provided 24 hour crisis resolution care and was compared to standard inpatient services. 260 people in need of admission to hospital were randomised. The investigators found patients were significantly less likely to be admitted to hospital eight weeks after receiving crisis intervention (odds ratio 0.19, 95% confidence interval 0.11 to 0.32). The intervention, however, did not reduce compulsory

admissions. Patient satisfaction was higher for the experimental group by a mean difference of 1.6, and statistically significant only after adjustment for baseline characteristics ( $p = 0.002$ ).

Reductions in admissions on a national scale following the introduction of CRTs were assessed by Glover *et al.* (2006) using routine data on admissions from the NHS (National Health Service). Data from 229 primary care trusts (PCTs) were analysed out of a total of 303. These data covered a six year period between 1998/9 to 2003/4. Despite the discrepancies in these data the authors found a reduction in admissions of 23% for younger people and 0.5% for older people. For people of all ages the median change was -11% (inter-quartile range +6%-23%). The reduction in occupied-bed days also decreased but the difference was much smaller at 10% and not statistically significant. As Glover and Johnson (in press) emphasise, this last finding raises an important question concerning the savings that can be made from inpatient care to fund CRTs over the long term.

## **Conclusion**

The implementation of CRTs, despite being slow to begin with, soon became rapid. The size, composition and functions of CRTs across the country vary enormously. Many CRTs struggle to meet the demands for the service and satisfy many of the fidelity criteria outlined in the MHPIG. The impact of CRTs has been demonstrated in the reduced numbers of hospital admissions. A decrease in bed-occupancy days, however, is less evident.

In the next section we outline the rationale for the study, highlighting the key areas of focus, and listing the aims and objectives, and propose a series of hypotheses.

## SECTION 3 – RATIONALE

The NHS Plan (DH, 2000) highlighted the importance of leadership to achieve modernisation within the NHS: “we need clinical and managerial leaders throughout the health service”. Within the field of mental health there have been frequent calls for clear and strong leadership (e.g., SCM, 1999). What is missing, however, appears to be clarity about the relationship between leadership and change. For this reason, an evidence base on how leadership factors impact on successful NHS Plan implementation within the NHS would be of enormous value.

Since the initiation of this project, two such studies have been reported (Borrill, West & Jackson, 2005a&b), and the evidence of their findings confirms the significance of the quality of leadership at different levels within the NHS. Thus, Borrill *et al.* (2005a&b) reported significant relationships between leadership behaviour in NHS trusts. Also, Borrill *et al.* (2005b) found statistically significant relationships between leadership and certain indicators of clinical governance, but the relationships with overall trust performance and with patient satisfaction did not reach the level of statistical significance.

During the period of this project, most areas of health and social care have been redesigning services to establish multi-disciplinary and multi-agency teams and networks. Thus, for example, the achievement of the NHS Plan clinical priority aims for cancer, coronary heart disease and mental health are largely dependent on service redesign to establish networks and teams (Carless Report, 2005). Unfortunately, the leadership models which currently dominate the literature have been based in the main on data collected in non-UK studies of commercial and military organisations and may be of limited validity in multi-professional, complex, public sector organisations such as the NHS, or are competency-based. With regard to the non-UK provenance of some models, although there are many common leadership factors across different organisations there are also important differences. Indeed, evidence suggests that integrity and stakeholder sensitivity, and a sense of partnership and ‘connectivity’ are more important in the public sector (e.g., Alban-Metcalfe & Alimo-Metcalfe, 2007; Alimo-Metcalfe & Alban-Metcalfe, 2001; 2002; 2005; 2006; 2007). Such a ‘distributed’ or ‘engaging’ model of leadership is much more conducive to leadership development, rather than to just leader development (Iles & Preece, 2006).

The NHS Plan (DH, 2000) sets a complex change agenda for health and social care services in England. This has involved on-going changes in organisational structures with the further development of Primary Care Trusts and strategic health authorities aimed at delegation away from the centre within a common context provided by mechanisms such as national service frameworks (DH, 2001a). The intention was that the process of achieving organisational and clinical change would be the focus of central and local activity, supported by the work of the Modernisation Agency and its Leadership Centre, and the NHS Institute for Innovation and Improvement. The envisioned radical improvement of mental health services, as set out in the first national service framework (DH, 1999), presented an opportunity to

learn about leadership and its impact on change processes in an area of clinical priority where organisational and clinical structures are complex. More recent changes in organisational and clinical structures have impacted on CRTs, with some of them fusing to form a single team.

This study takes as its basis for change the implementation of mental health crisis resolution teams (CRTs). A Mental Health 'Policy Implementation Guide' (PIG) specifies how these teams should be structured with multi-disciplinary and multi-agency input (DH, 2001b). Each team should have 14 dedicated staff, including a team leader. Staff should come from community psychiatric nursing, social work, psychology, occupational therapy and medical backgrounds. The team should operate 24 hours a day, every day of the year. At any one time the team would be working intensively with 20 to 30 people who have a severe mental health problem, which might lead to them requiring inpatient care. The team ethos should be to treat people in their own homes and only to use hospital care when absolutely necessary. It was anticipated that, as a consequence, the development of CRTs would reduce the need for inpatient admission and reduce the length of stay for those who are admitted, by facilitating early discharge.

An established evidence-base for the effectiveness of CRTs has been seen as an essential building block of contemporary mental health care (Ford *et al.*, 2001; Joy *et al.*, 1998; Marks *et al.*, 1994). Across the country, CRTs aim to treat 100,000 people in their own homes who would otherwise have been admitted to hospital. However, crisis services can be difficult to establish and could increase the use of hospital beds if they did not act as a filter to all admissions (Ford & Kwakwa, 1996; Hogan & Orme, 2000), i.e., if they did not perform a 'gate-keeping' role. To act as a filter, and hence to achieve the desired outcome, whole system change was seen to be required: CRTs cannot function effectively as a 'bolt on' extra. The implications of this include that consultant psychiatrists, inpatient wards and community teams would have to change the way that they work. The change associated with the introduction of CRTs would, therefore, typically involve complex, multi-agency, multi-disciplinary processes. This has been a common theme throughout the modernisation of health care where effective services are delivered by partnership teams working across traditional boundaries.

The changes envisaged a situation in which the leadership to achieve change would be vested in several key people who would use different styles. The establishment of community-based CRTs would be likely to require executive, network and line leadership (Senge, 1999), as well as clinical leadership (Halligan & Donaldson, 2001), and local champions (Howell & Higgins, 1990). NHS Trust chief executives, directors of social services departments and professional leads, such as medical, nursing and social work directors are likely to be in executive positions and should use a 'transformational' or 'engaging' style of leadership (Alimo-Metcalfe & Alban-Metcalfe, 2001; 2007). It is to be anticipated that the new CRT leaders would need transformational skills to establish the team and a more transactional style as the team changes emphasis from formation to long-term service provision. However, in order to sustain a highly motivated and effective team, transformational

leadership must be combined with transactional leadership at all levels. Such leadership needs to be embedded in the organisational culture to maintain long-term effectiveness (e.g., Alimo-Metcalfe & Alban-Metcalfe, 2001; 2006; Bass, 1998).

Leadership brings about desired outcomes through change management processes. The evidence base for these change management models has recently been reviewed (Iles & Sunderland, 2001), and the extent to which they are used is examined in the present study. Leadership interacts also with contextual factors that may frustrate or enhance its positive effects (e.g., Dixon, 1994; Gibbons, 1999). Pilot work has shown the importance of obstacles such as organisational upheaval (Bryson, 2002). Other factors that are associated with the leadership culture of a CRT include: - staff, team and organisational characteristics such as the age of the team, its client case mix, and whether the team is a gate-keeper for in-patient admissions (Corrigan *et al.*, 2000; Niemiec & Tacchi 2003).

These characteristics are important to the present study since the implementation of CRTs has been patchy and slow with many teams failing to meet all the criteria specified in the policy implementation guide.

When the project was first started, fewer than 50% had 14 staff members or more (Durham Mapping Sept. 2003), and far fewer provided a gate keeping function for all in-patient admissions (personal communication: John Hoult, Stephen Niemiec).

Fidelity to the model of CRT provision specified in the policy implementation guide is assessed in this study.

In summary, a leadership culture is not created by a single individual but is distributed in nature, and reflects the contributions of people inside and outside of the team. Both the leadership processes and the change management processes employed by leaders are subject to contextual factors that may frustrate or facilitate progress. CRTs need to meet service model fidelity criteria if they are to manage patients in the community and avoid hospital admissions. These criteria reflect intermediate outcomes to be achieved by CRT leaders. So-called 'softer' qualities such as staff attitudes to work and well-being at work (e.g., Patterson, Warr & West, 2004) are also important in this respect. The proposed study will explore these relationships and build on contemporary research by developing our knowledge of successful transformational and transactional leadership styles used by multiple leaders in complex, multi-agency health care settings. This will generate practical recommendations for those responsible for ensuring that change occurs. An evidence base will be available to assist in the selection of leaders and to help them develop and use styles that have been linked to successful change.

## Aim and Objectives

The aim of the study is to understand what combinations of leadership factors are associated with the effective development and delivery of new services?

The objectives of the study are to:

- Measure the leadership climate of CRTs
- Identify any change management models used in the development of the CRTs
- Describe the staff, team and organisational characteristics of each CRT
- Assess the fidelity of each team to an evidence based model of CRT provision
- Track the number of referrals to each CRT and the proportion who are admitted for in-patient care<sup>10</sup>
- Interview key personnel in CRTs with a high and low proportion of referrals who are admitted for in-patient care

## Hypotheses

The primary hypothesis for the study is:

Hypothesis 1: That the quality of leadership exhibited by the leaders of Crisis Resolution Teams is directly related to team effectiveness.

This hypothesis will be tested through subsidiary hypotheses that specify which leadership factors are associated with two aspects of team effectiveness: (a) staff attitudes to work and their well-being at work; (b) effective service provision, when staff, team and organisational characteristics are controlled. Thus:

Hypothesis 2: That the quality of leadership of CRTs is positively associated with staff attitudes to work and well-being at work.

Hypothesis 3: That the quality of leadership of CRTs is positively associated with a higher *ratio* of the number of assessments made by the team in relation to the number for referrals to in-patient care.

Hypothesis 4: That the quality of leadership of CRTs is positively associated with a *change* in the ratio of the number of assessments made by the team in relation to number of referrals to in-patient care, over a 12-month period.

Hypothesis 5: That the quality of leadership of CRTs is positively associated with higher *productivity* which reflects a higher ratio of assessments made by the team to referrals to in-patient care, as a function of the ratio of staff to service users.

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<sup>10</sup> It was planned, initially, also to measure lengths of stay, but these data could not be obtained.

Hypothesis 6: That the quality of leadership of CRTs is positively associated with a *change in productivity*, as measured by an increase in the ratio of the number of assessments made by the team in relation to number of referrals to in-patient care, over a 12-month period, as a function of the ratio of staff to service users.

The difference between Hypothesis 3 and Hypothesis 4 is that, whereas Hypothesis 3 is concerned with the *ratio* of assessments to referrals, Hypothesis 4 addresses any *change* in the ratio over time.

Similar, Hypothesis 5 is concerned with *productivity*, whereas Hypothesis 6 is concerned with any *change* in productivity over time,

The further hypothesis about the relationship between the leadership of the team and the way in which change is handled will also be tested:

Hypothesis 7: That a more enabling or transformational style of leadership is associated with a more transformational approach to managing change.

The next section, Section 4, describes the methodology that was adopted in order to test these hypotheses.



## **SECTION 4 – METHODOLOGY**

### **Sample**

Contact was made with all the mental health crisis resolution teams (CRTs) in England that, according to the Durham Mapping, showed 'fidelity' to the model (DH, 2001b). The selection criteria were: - being multi-professional in their composition; having the services of a psychiatrist full-time or part-time; operating a service 24 hours per day, seven days per week, and 365 days per year.

A total of 120 teams were contacted, of which 116 agreed to participate. Each of these teams was sent a letter explaining the nature of the project and requesting their participation. The letter was followed up by a telephone call from a member of staff from Real World Group (RWG) or Sainsbury Centre for Mental Health (SCMH), (a) to explain more fully the nature of the project and the amount of involvement required, and (b) to arrange a visit to the team.

### **Plan**

Our inclusion criteria were based on three of the six fidelity criteria specified in the MHPIG (2001). Our four inclusion criteria were chosen given they were also those used for the Durham Mapping of CRHTs. In doing this we were able to use the Durham Mapping database ([www.dur.ac.uk/service.mapping](http://www.dur.ac.uk/service.mapping)) to both identify and sample existing CRHTs. The main distinction between the inclusion and fidelity criteria is the length of time a team had been operational, the provision of intensive support over a short period, staff in frequent contact with service users and to stay involved until resolution of the crisis. Table 4.1 (overleaf) shows the differences and overlap with the inclusion criteria used for the purposes of our study and the fidelity criteria listed in the MHPIG (2001).

A letter, signed jointly by Real World Group (RWG)<sup>11</sup> and Sainsbury Centre for Mental Health (SCMH), was sent to each of the CRTs that met the criteria, asking them to participate in the research. The letters were followed up by a telephone conversation with the Team Lead, explaining the nature of the investigation and soliciting their co-operation. The Durham Mapping database continued to be monitored to identify and to recruit further teams that met the criteria for inclusion in the project.

To assist with achieving a high response rate, the researchers briefed the National Institute for Mental Health (NIMH) in England, with whom contact has been maintained. In order to engender cooperation in the project, presentations were made at two NIMH meetings.

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<sup>11</sup> Formerly 'Leadership Research & Development Limited'.

<b>Table 4.1 – Relationship between inclusion criteria and fidelity criteria</b>	
<b>Inclusion criteria for present study</b>	<b>Fidelity criteria outlines in MHPIG (2001)</b>
Multidisciplinary (at least 10 staff, with at least two disciplines, plus dedicated psychiatrist, either full-time or part-time) Operational for at least 6 months	A multidisciplinary team  -
Operating 24/7, 365 days per year	Availability to respond 24 hours a day, 7 days a week
Delivering services in the patient's own home/community	Capacity to offer intensive support at service users' homes Staff in frequent contact with service users, often seeing them at least once on each shift Staff stay involved until the problem is resolved Provision of intensive contact over a short period of time

### **Data collected**

#### **Quality of Leadership and Attitudes to Work**

All CRT staff, key executive, network, line and professional leaders were asked to complete a questionnaire about leadership in their CRT. The instrument used was the 'Leadership Climate and Change Inventory (LCCI)<sup>TM</sup>' (Alban-Metcalfe and Alimo-Metcalfe 2003). The provenance of LCCI<sup>TM</sup> is items derived from two instruments researched and developed by Alimo-Metcalfe and Alban-Metcalfe, the 'TLQ<sup>TM</sup>' and 'Integration<sup>TM</sup>' (see 'Instruments'). The LCCI<sup>TM</sup> also collects information about 'attitudes to work' and 'well-being at work'.

Immediately prior to data collection, each team was visited by a member of the research team at RWG or SCMH. At this meeting, the nature and purpose of the research were explained, both to the Team Lead and as many staff as were in the office at the time, certain contextual data were collected. It was also explained that more detailed, case study data would be requested from a small number of teams. LCCI questionnaires were either distributed during the visit or left to be distributed, along with letters to be signed by each participant stating their willingness to participate and giving them the option to withdraw at any time, if they so wished.

Data were collected for each team providing a profile of its leadership behaviour from the perspectives of all staff (senior and middle management; operational; administrative). Paper and pencil format was used throughout, in order to ensure confidentiality and anonymity, respondents were asked to

return completed instruments, directly to RWG/SCMH, using a FREEPOST envelope provided.

### **Contextual Data**

The contextual data were requested from each CRT<sup>12</sup>:

- Number of assessments undertaken at the beginning of the project (baseline) and 12 months later
- Number of referrals to in-patient provision at the beginning of the project (baseline) and 12 months later
- Availability of alternatives to in-patient care
- Whether the CRT performed a gate-keeping role, and if so, whether this was total or partial
- Whether or not the team had a dedicated psychiatrist
- Mental Illness Needs Index (MINI) Score for locality
- CRT case mix (proportion with psychosis)
- Age of team
- Number of staff involved in working on a single case.

A standard pro forma was used by each team to track the number of referrals and the proportion who are admitted for in-patient care.

The data were to be collected during the baseline year (2004/05) and after one year (2005/06). However, as illustrated in the case studies, some teams did not provide the data in this detail for the full 12-months, the decision was taken, therefore, to ask those teams that had not responded, or who had provided incomplete results, to provide *average* data for the 12 month period. Average score were used to calculate the *ratio* of assessments made by the team to referrals to in-patient care, differences in ratios were used to calculate *change* scores.

### **Change Models**

CRT leaders were approached to establish which, if any, change management models have been used locally. In order to do so, telephone interviews were conducted with each Team Lead, with the responses recorded in a standard format, with the questions sent to the respondent in advance.

The purpose of this interview was: -

- to determine certain factual information about the team, e.g., how long it had been established, and identify any issues or challenges;
- to identify any major change or significant development involving staff that had occurred over the last two years, and how they had been addressed;

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<sup>12</sup> Whether the team lead was also a psychiatrist was also recorded. However, as only 2 team leads fell into this category, this variable was not used in subsequent quantitative analyses.

- to identify any major or significant change to the management or functioning of the team that involved staff, to specify what the implications were, and how the issues had been addressed;
- to identify any major or significant change to the management or functioning of the team that involved external agents, to specify what the implications were, and how the issues had been addressed;
- to specify which individuals (senior staff; all staff; users and carers; external agents) were involved in any conflict or change, and to determine how the issues were resolved;
- to determine the amount of change activity involving senior staff that could be regarded as corresponding to each of three models of change (incremental; unfreeze-move-freeze; developmental/iterative);
- to determine the amount of change activity involving all staff could be regarded as corresponding to each of three models of change (incremental; unfreeze-move-freeze; developmental/iterative);
- to ascertain the extent to which one or more of the change models described by Iles and Sutherland and/or the NHS Modernisation Agency and NIMH models had been used, and to evaluate its/their use;
- to ascertain the extent to which one or more of the change techniques described by Iles and Sutherland and/or another technique had been used, and to evaluate its/their use.

The following data were collected during the course of the project. In some cases, this was based on interviews with one or members of the team; in other cases, questionnaires were used.

## **Instruments**

- ***'Leadership Climate and Change Inventory' (LCCI)™***<sup>13</sup>

The LCCI™ comprises three questionnaires, which assess: (1) transformational aspects of the leadership climate; (2) capability aspects of the leadership climate; (3) attitudes to work and well-being at work (see Appendix 1).

The LCCI has a total of 119 items. The response categories for the items are as follows:

1 'Strongly Disagree'; 2 'Disagree'; 3 'Slightly Disagree'; 4 'Slightly Agree'; 5 'Agree'; 6 'Strongly Agree'; D 'Don't Know'; N 'Not Relevant'.

All the items are positively framed so that 6 is a positive score and 1 is a negative score.

The items that assess the transformational aspects of the leadership climate were derived from the 'Transformational Leadership Questionnaire' (TLQ)™. This instrument was based on an empirical study of leadership among over 4,000 managers and professionals working in local government and the NHS

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<sup>13</sup> Formerly known as the 'Leadership Culture & Change Inventory'

(Alimo-Metcalfe & Alban-Metcalfe, 2001, 2005, 2006). The research, which used a ‘grounded theory’ approach, was inclusive in respect of gender, ethnicity, and level in the organisation. Subsequent empirical research has replicated the findings in private sector organisations (Alimo-Metcalfe & Alban-Metcalfe, 2007) and among police officers and staff (Dobby, Anscombe & Tuffin, 2004). The validity of the model has also been established in other contexts (e.g., Miller, 2004; Kelly, Johnson & Gill, 2006).

The leadership capability items were based on a literature search of leadership competencies, which were then rated for relevance by a total of  $n = 35$  middle and senior managers and professionals working in the area of mental health.

Attitudes to work and well-being at work were those used by Bass and Avolio in their initial validation of the MLQ (e.g., Bass, 1985), plus ‘reduced job-related stress’ (Alimo-Metcalfe & Alban-Metcalfe, 2001). A review of the literature suggested that these be augmented by a further eight items, as shown in Table 4.2):

<b>Table 4.2 – Items used to measure different aspects of attitudes to work and well-being at work</b>	
<b>Item</b>	<b>Source</b>
A high level of job satisfaction	Bass (1985)
A high level of motivation to achieve	
Staff who are motivated to achieve beyond their expectations	
A low level of job-related stress	Alimo-Metcalfe & Alban-Metcalfe (2001)
A high sense of fulfilment among staff	Review of the literature
A strong sense of job commitment	
A strong sense of commitment to the organisation	
A high level of self-confidence	
A high level of self esteem among staff	
A strong sense of team spirit	
A strong sense of team effectiveness	
A low level of job-related emotional exhaustion	

Since the LCCL is being used for the first time in this sector, the research provides an opportunity to determine which of the items are directly relevant to assessing quality of leadership within CRTs, and thereby establish its face, content, discriminant and predictive validity.

#### *Choice of items*

Three of the dependent variable items (concerned with ‘job satisfaction’, ‘motivation’, and ‘motivation to achieve beyond expectations’) were used by Bass in his initial studies to establish the convergent validity of the MLQ (e.g., Bass, 1985). The same items, along with ‘Causes me to have low level of job-related stress’, were also used by Alimo-Metcalfe and Alban-Metcalfe (2001) to establish the convergent validity of the TLQ. The latter item was included in light of evidence of high levels of stress among staff working in the NHS (Borrill *et al.*, 1996, 1998). The other eight items were included on the basis

of a wide ranging review of the literature on the relationship between organisational culture and impact on staff (e.g., Parker *et al*, 2003).

#### *Use of single items*

The decision to use single items or 'facets', rather than one of the existing scales that measure the relevant dependent variables, was based on the analyses of Nagy (2002), Scarpello and Campbell (1983) and Wanous, Reichers and Hudy (1997). On the basis of a review of overall measures of job satisfaction, Scarpello and Campbell (1983) concluded that a one-item, 5-point scale that simply stated as, "Overall, how satisfied are you with your job?" is the best global rating of job satisfaction. They and others (Ironson, Smith, Brannick, Gibson & Paul, 1989; Wanous *et al.* 1997) believe that, because multi-item scales may neglect some components of a job that are important to an employee, single-items measures may be superior to calculating a simple average of the scores on a multi-item scale. Thus, for example, simply adding up facets to calculate an overall index of job satisfaction may exclude important aspects of an employee's job that affect her/his overall satisfaction. Furthermore, as demonstrated by Heneman and Schwab (1985), even a facet of job satisfaction, such as 'satisfaction with pay', may itself comprise sub-facets (specific areas) of pay.

Also, as noted by Scarpello and Campbell (1983), summing facets that are *not* important to an employee's satisfaction will lead to misleading conclusions about their overall satisfaction level. Thus, although most multiple-item scales have been based on a tremendous amount of research that has sought to justify and validate the selection of items, it remains "extremely likely that there are individual differences among employees that help to determine their satisfaction with a particular facet" (Nagy, 2002, p.78).

Two areas in which single-item measures are open to criticism are in relation to reliability and to the extent to which they are correlated with scale measures, i.e., evidence of their concurrent validity. It is certainly the case that, because of their nature, they cannot be used to calculate internal consistency. However, significant correlations have been found between single-item and corresponding multi-item scales. Thus, Wanous *et al.* (1997) demonstrated that single-item measures of 'overall job satisfaction' correlated at the level of  $r = 0.67$  with multiple item, or scale, measures of the same construct. They went on to conclude that single-item measures of overall job satisfaction "are more robust than the scale measures of overall job satisfaction" (p. 250).

Similarly, Nagy (2002) reported significant correlations (range  $r = 0.60 - 0.72$ ,  $p < .01$  in each case) between scales of the Job Descriptive Index (Smith *et al*, 1989) and single-items measures of five facets of job satisfaction (work itself, pay, promotions, supervision, co-workers).

These and other considerations have led to a combination of statistical and non-statistical reasons why a single-item measure of job satisfaction may be preferable to scale measures. These include that single-item measures: - (1) usually take less space than scale measures; (2) may be more cost-effective;

(3) may have more face validity, especially when an organisation has poor employee relations, owing to negative reactions to perceived repetitive questions; (4) may be better to measure change in job satisfaction (Wanous *et al*, 1997); and (5) result in questionnaires that are shorter and more likely to be completed by employees, thereby reducing the response rate (Nagy, 2002).

### ***Analysing Change Questionnaire***

Team's experience of change was assessed using an instrument designed to gain information in relation to: -

1. processes of setting up the team  
changes involving internal staff  
changes to the management and functioning of the team
2. changes involving external agents
3. people that were involved with changes, including examples of any conflict and how it was resolved
4. senior management involvement in types of change  
all staff involvement in types of change
5. models used when implementing change, and an evaluation of them
6. techniques used when implementing change, and an evaluation of them (Appendix 2).

The questionnaire was piloted with four CRTs and modified in the light of comments.

In relation to '4', 'senior management involvement in types of change' and 'all staff involvement in types of change', three models of change were proposed:

- incremental
- unfreeze-move-freeze
- developmental/iterative.

As noted earlier, the first two have been described as reflecting "gratification-driven culture", whereas the third, which is designed to achieve "continuous learning & transformational change" is characteristic of "value-driven cultures" (Sathe & Davidson, 2001, p.293).

### **Definition of team performance**

Admission rates to psychiatric hospitals as a main outcome measure has been both a focus of government policy and used in evaluations to determine the effectiveness of a series of community-based mental health services introduced over the past decade; namely Crisis Resolution Teams, Assertive Outreach, and Intensive Case Management.

For Crisis Resolution Teams two key evaluations have utilised admissions to hospitals and the extent to which these are reduced. Glover *et al*, (2006), for example, using NHS routine admissions statistics, examined admissions for both Crisis Resolution and Assertive Outreach; they found trends to suggest reduced admissions since the implementation of both teams. Johnson and colleagues (2005a & b) in a before and after evaluation and a randomised controlled trial of a CRT in North London used admissions as their main outcome measure and found significant reductions. Similarly, a large scale randomised trial also used admissions to hospital as a primary outcome measure to assess the effectiveness of Intensive Case Management (ICM) – a community based mental health service working intensively with service users with severe mental health problems and reduced case load sizes (Burns *et al*, 1999). They found, however, no differences in admissions in ICM when compared to Standard Case Management.

Use of admission rates as a measure of effectiveness therefore is not unusual and indeed something targeted by government policy and research evaluations alike.

Four kinds of performance score were calculated: ratio; change; productivity; and change in productivity.

**Ratio:** The ratio is defined as the number of assessments made by the team to the number of referrals for in-patient care as an average over a 12-month period.<sup>14</sup>

A *low* score indicates fewer in-patient referrals per assessment.

**Change:** – Change is defined as any difference in the ‘ratio’ over a twelve month period.

Since there was evidence of month-by-month fluctuations, baseline scores were calculated as the average of months 1 and 2, and final scores as the average of months 11 and 12.

A *high* score indicates greater effectiveness.

**Productivity** – This was calculated by dividing the ‘ratio’ scores by the ratio of the number of assessments made by the number of members of the team.

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<sup>14</sup> Ratio scores were calculated with reference to number of assessments made by the team, rather than number of individuals referred to the team. This was because it became evident that, partly owing to the lack of the clarity about the role and remit of CRTs, and partly owing to lack of clarity as to which users should be treated by CRTs rather than CMHTs, a significant number of referrals were inappropriate (cf. Garcia, 2006). To have used such data would have given a false picture, particularly where teams were relatively recently established, and their terms of reference not widely known or fully understood.



A *low* score indicates higher 'productivity'.

***Change in productivity*** – This was calculated by comparing the average 'productivity' during months 1 and 2 with that during months 11 and 12.

A *high* score indicates higher 'productivity'.

## **Statistical Analyses**

In order to undertake quantitative analyses of the data, the following statistics were used:

### ***Descriptive statistics***

The results were grouped into different categories, e.g., the actual number of CRTs offering a 24/7, 365 days per year in 'office service', as against offering a 24/7, 365 days per year 'telephone-initiated service'. In other cases, the average or 'mean' score for a group was calculated, along with the range (highest to lowest) and the standard deviation. Calculation of the standard deviation provides a measure of the 'spread' of scores, which is often in the form of the familiar 'bell-shaped' curve.

### ***Inferential statistics***

This kind of statistic enables judgements to be made as to whether, for example, the scores reported for one group are the same as, or are actually greater or lesser than those reported for another group, or two sets of measurements are correlated with each others, or there is any evidence of a cause-effect relationship.

### **T-tests and Tukey's HSB:**

When testing whether or not the scores reported for one group are the same as, or are actually greater or lesser than those reported for another group, one of the commonly used statistics is the 't-test'. However, in the present research a slightly more sensitive test, called 'Tukey's HSB' has been used. Both tests can be calculated using a standard SPSS package.

### **Analysis of variance:**

Where comparisons are to be made between three or more groups, it is necessary first to undertake a 'one-way analysis of variance' test (ANOVA). Put simply, this statistic calculates how much variation in a set of results is shared in common by all the groups together (the 'within-group variance'), and compares this with how much variation in each of the groups can be attributed to the different conditions that apply only to that group (the 'between-groups variance'). When three or more groups are involved, t-tests or Tukey's test can only be applied if the between-groups variance is significantly greater than the within-groups variance; failure to ensure that the ANOVA statistic reaches the level of statistical significance could result in a 'Type I' error –

which would be to conclude that means scores are different when they are not.

Correlation coefficient:

Two variables are said to be correlated if changes in one variable are associated with changes in the other variable (Hair, Anderson, Tatham & Black, 1998). A correlation coefficient ( $r$ ) is a measure of the strength of this relationship, and can range from -1.0 (fully negatively correlated), through 0.0 (totally independent), to 1.0 (fully positively correlated).

Principal components factor analysis:

This is a technique for looking for patterns of relationships between variables, by identifying where two or more items are strongly correlated with each other, and whether items appear to be more or less independent. Those items that are strongly inter-related become grouped together or the same 'principal component' or 'factors'. Depending on how strongly items are inter-correlated, any number of factors from one upwards emerge. In essence, this results in the data being simpler and easier to understand and interpret.

Regression analysis:

Regression analysis is a technique for estimating the extent to which an 'independent variable', such as 'quality of leadership', and a 'dependent variable', such as 'job satisfaction', are related. The 'regression coefficient' represents the amount of change in the dependent variable for a one-unit change in the independent variable. Again, in essence, it is possible to find out where particularly strong relationships exist, and can be the first stage towards identifying where there may be cause-and-effect relationships.

Stepwise multiple regression analysis:

This is a particular application of regression analysis, and the same principle applies in stepwise multiple regression analysis. In stepwise multiple regression analysis the method of selecting variables for inclusion in the 'regression model' is one that starts by selecting the best predictor of the dependent variable. Additional independent variables are selected in terms of the incremental explanatory power they can add to the regression model. Independent variables are added as long as their 'partial correlation coefficients' are statistically significant, but may also be dropped if their predictive power drops to a non-significant level when another independent variable is added to the model.

In this way, the 'best' way of accounting for differences in the dependent variable is achieved, with reference to all the independent variables that have been measured. The stepwise procedure is adopted when there are reasons for believing that the independent variables may be significantly inter-correlated.

Hierarchical multiple regression analysis:

The same principle applies in hierarchical, as in stepwise multiple regression analysis, except that the assumption is made that the independent variables are independent of each other.

As with the stepwise technique, the 'best' way of accounting for differences in the dependent variable is achieved, with reference to all the independent variables that have been measured.

Structural equation modelling (SEM):

This is a technique for estimating the extent to which a series of dependent and independent variables are inter-related. It does so by combining aspects of multiple regression and factor analysis. The objective is to try to establish cause-effect relationships.

### **Case Studies**

A series of case studies were undertaken to explore, in depth, the way teams with high and low admissions to hospital functioned on a day to day basis, observe relationships between staff, the perceptions of good leadership within the team and gather examples of how the team established itself within the broader community and the way it works with external agencies, and the underlying pressures and the factors influencing admissions to hospital. We also explored the organisational and operational features of the CRTs selected. Issues of performance and efficiency will be examined in relation to hospital admissions.

Case Studies were undertaken with a total of eight teams. Teams were selected on the basis of the admissions data they provided us. At the time in the research plan when it was necessary to select the case studies, not all the teams had provided all the relevant information on which to make a selection. Accordingly, the selection was from the teams that had provided us with the relevant admissions data.

Once the 'high admission' and 'low admission' teams had been identified, teams were contacted to ask if they would be a Case Study organisation. In each case, the team was contacted by telephone. The reason why the team had been selected was not stated at the time, nor subsequently; rather, it was reiterated simply that collection of Case Study data was an integral part of the project.

In the event, it proved more difficult to obtain the participation of 'high admission' teams, with the results that only 3 (rather than 4) of such teams were involved. Clearly, a major factor is deciding whether or not to participate so intensively could be due to the pressures under which they operate. Accordingly, a total of 5 'low admission' teams were approached and agreed to participate in this element of the research.

### **Conducting the case studies**

Data collection was primarily through in-depth interviews with CRT members, and, where possible, external stakeholders e.g., from CMHTs etc. In addition, observations were carried out and attendance of team meetings took place where permissible. In essence a very pragmatic approach was adopted in

conducting the case studies. It was recognised that CRTs are very busy, with team members constantly being in the office for very brief periods at one time, in between working with service users. Some teams also work in one main, often crowded, office, which occasionally made it difficult to find a private space to interview staff. In two cases, it was necessary to conduct the interviews in the main office. Clearly, these do not constitute ideal conditions for conducting research, but on the positive side, it did provide an opportunity to observe the functioning of the team.

Case study teams were visited by one researcher for a period of 1-2 days. Researchers aimed to interview CRT staff and, where available, external stakeholders. Stakeholders that were targeted included:

*External agencies*

- CMHT staff
- A&E staff
- Alternative crisis service staff
- Hospital doctors/consultants on inpatient wards

*Crisis resolution team members*

- Psychiatrist
- Social workers
- Secretaries/administrators
- Psychiatric Nurses
- Volunteers or support workers
- Occupational therapists

*Data collection*

The data collected for the case studies were primarily qualitative. A topic guide was developed (see appendix 3) to cover issues concerning:

- a) admissions;
- b) gatekeeping role;
- c) systems of referrals;
- d) how other agencies (CMHTs, A&E departments, GPs) perceive the role of CRTs;
- e) alternatives to inpatient care and whether CRTs have close links with these in their local area
- f) barriers to working effectively
- g) perceptions of good leadership
- h) what constitutes a successful team – how is this determined and by whom?

Interviews varied in length, lasting from 15 minutes up to 1 hour. Interview data was supplemented by opportunistic use of non-participant observation, for instance through attendance at team and other relevant meetings. Where possible any relevant documentation, such as policy papers and minutes of meetings were also included.

### *Data analysis*

Interviews were audio-recorded, with prior consent of the interviewee, transcribed and entered into NVivo qualitative data software for analysis. However, where some interviewees felt uncomfortable about being recorded, detailed notes were taken instead. Analysis of case study data involved identifying key themes relating to the way the team conducted its duties, the perceptions of leadership among staff members, relationships between staff members and how the team worked with external agencies.

## Timing of data collection

The periods during which the different kinds of data were collected are summarised in Table 4.3.

### YEAR 1

Jan	Apr	Jul	Oct
		Visits to all participating CRTs; one-to-one meeting with Team Lead and some staff to explain project and ensure co-operation	
		Collection of referral and admissions data (monthly records) (on-going)	
		First administration of LCCI	

### YEAR 2

Jan	Apr	Jul	Oct
Visits to all participating CRTs; one-to-one meeting with Team Lead and some staff to explain project and ensure co-operation (Note 1)			
Collection of referral and admissions data (monthly records) (on-going)			
First administration of LCCI (Note 2)			
	Collection of change management data		
		Second administration of LCCI	

### YEAR 3

Jan	Apr	Jul	Oct
Collection of referral and admissions data (monthly records) (on-going)			
Collection of change management data			
Second administration of LCCI			
		Collection of case study data	

Note 1: The Durham Mapping database continued to be searched to identify any additional teams that met the inclusion criteria. Such teams were only contacted and invited to participate once they had been established for 6 months.

Note 2: Completed LCCI questionnaires from a given team were received over a period of up to 6 months after initial distribution.

## SECTION 5 – RESULTS 1: QUANTITATIVE ANALYSES

### Background information

Of the total of 120 CRTs that were identified as meeting the fidelity criteria of operating 24 hours per day, 365 days of the year, of having at least 10 team members, of being multi-disciplinary, and of having the services of a psychiatrist, 116 agreed to participate in the research. The teams were from the different regions of England, and were located in urban, semi-urban and rural areas.

For each of the teams, data were collected about the leadership climate within the team, staff attitudes to work (job satisfaction; motivation; motivation to achieve beyond expectations; job commitment; organisational commitment; team spirit; sense of team effectiveness) and sense of well-being at work (fulfilment; self esteem; self confidence; reduced job-related stress; reduced job-related emotional exhaustion), and contextual information (average proportion of cases with psychosis ('psychosis'); Mental Illness Needs Index for the area ('MINI'); alternatives to in-patient provision (alternatives); age of the team at the start of the study; number of staff working with each case; the extent to which the team performed a gate-keeping role; the extent to which the team could draw on the services of a psychiatrist; the number of different professional disciplines within the team; the nature of the 24 hour cover.

The contextual data for the teams is summarised as follows:

<b>Psychosis (per cent)</b>	Range	Mean	SD
	10 – 70	30.0	17.0
<b>MINI scores</b>	Range	Mean	SD
	0.61 – 1.86	1.09	0.45
<b>Alternatives to residential care</b>	No	Yes	
	19	27	
<b>Age of team (years)</b>	Range	Mean	SD
	2 - 15	3.75	1.78
<b>Staff per case</b>	Range	Mean	SD
	0.5 – 2.33	1.59	1.60
<b>Gate-keeping role</b>	None	Partial	Complete
	3	26	71
<b>Dedicated medical cover (psychiatrist)</b>	None	Part-time dedicated	Full-time dedicated
	16	25	59

Although fidelity to the model requires that a team has a dedicated psychiatrist full-time or part-time, the evidence was that at the time of the second interview, some teams did not have such a facility available to them. To have eliminated such teams would have reduced the sample size significantly, and so an additional category was created for scoring purposes.

The extent to which a range of disciplines was represented in a given a team was as follows:

<b>Multi-disciplinary</b>	Nurse only	Multi-disciplinary
	16	84

Again, although fidelity to the model requires that a team is multidisciplinary, the evidence was that at the time of the second interview, some teams comprised only a team lead, a psychiatrist and nursing staff. Once again, to have eliminated such teams would have reduced the sample size significantly, and an additional category was created for scoring purposes.

Teams were categorised as having full 24/7, 365 cover in which staff were in the office all the time, *versus* having 24/7, 365 cover in which staff were available throughout each day, but only when contacted through a telephone service. The proportion of teams in the two categories was as follows:

<b>Service cover (per cent)</b>	24/7, 365 in office	24/7, 365 telephone-initiated service
	94	6

Although when contacted initially all teams fell into the first category, in response to a pattern of demand that suggested that most crises occur during the day, some teams had decided to offer a telephone-initiated service between certain hours, e.g., 22.00 – 08.00. As argued previously, to have eliminated such teams would have reduced the sample size significantly, and an additional scoring category was created for purposes.

A total of 46 teams provided data in all of these categories. The reasons for the attrition was partly owing to

- the pressure that the teams were working under in order to provide the service, in some cases under adverse conditions, e.g., two teams working in a space that had previously been occupied by a single team;
- the amalgamation of teams;

and may or may not have been affected by their participation in another, parallel study of CRTs.

When data were not forthcoming, a number of approaches were adopted. These were: - repeated emails to the team lead; letters to the team lead;



telephone calls to the team lead or the secretary; reminders of the value of the data; reminders that their own team's data would be fed back to them; an invitation to a conference at which all the data would be presented (anonymously). In addition, MREC approval was sought and obtained to reward teams that had a high proportion of returns of the LCCI™ by putting them in one of two draws (one for the south or England, the other for the midlands and north of England) for a £100 gift token.

The results from the teams for which complete data were collected are presented in Table 5.1

**Table 5.1 – Contextual data**

	<b>Number of CRTs</b>	<b>% of total number of CRTs</b>	<b>% of CRTs who agreed to participate</b>
Teams approached	120	100	
Teams who agreed to participate	116	91.7	100
Teams for whom responses received to LCCI	90	75.0	74.6
Teams potentially contributing to dataset, after removal of teams that did not meet the criterion of either more than 4 responses to the LCCI, or at least 20% of team members responded to LCCI™	72	60.0	80.0
Teams contributing fully to dataset (LCCI data, full admissions data, and contextual data)	46	38.3	63.9

## **The Relationship between Quality of Leadership and Team Effectiveness**

### **Hypothesis 1**

The primary hypothesis for the study was (Hypothesis 1): That the quality of leadership exhibited by the leaders of Crisis Resolution Teams is directly related to team effectiveness.

This hypothesis was tested through subsidiary hypotheses that specify which leadership factors are associated with two aspects of team effectiveness: (a) staff attitudes to work and their well-being at work (Hypothesis 2); (b) effective service provision, when contextual factors are controlled (Hypotheses 3-6).

### **Relationship between Quality of Leadership and Attitudes & Well-being**

#### **Hypothesis 2**

This was: That the quality of leadership of CRTs is positively associated with staff attitudes to work and well-being at work.

The quality of leadership of the team data and the data about staff attitudes to work and well-being at work were collected during a single administration of the LCCI. In order to determine which aspects of leadership climate were relevant to the CRTs, the results for  $n = 731$  staff, of whom 429 stated that they were female and 277 that they were male.

### **Structure and validity of the LCCI**

The sample was divided into two groups of  $n \geq 365$ , and an exploratory principal components factor analysis of the 'culture scale' items for Group 1, with oblimin rotation, led to the emergence of three factors, which accounted for 59% of shared variance. Following confirmatory analysis with Group 2, a similar structure emerged, which was found to hold true for the combined sample. However, as factor 3 comprised only three items which were not readily interpretable, it was discarded.

These were interpreted and the items used to form two 'leadership culture' scales, which were labelled: -

- 'Engaging with Others' – 16 items;  $\alpha = .95$ ; inter-item  $r \geq 0.54$ ; coefficient of variation (CoV) = 26.7
- 'Visionary Leadership' – 7 items;  $\alpha = .89$ ; inter-item  $r \geq 0.43$ ; coefficient of variation = 21.6 (Table 5.2).

Corresponding analyses of the 'capabilities' scale items resulted in the emergence of a single factor, one of which was concerned with individuals and relationships and the other with systems and processes. This was labelled: -

- 'Leadership Capability' – 14 items;  $\alpha = .94$ ; inter-item  $r \geq 0.36$ ; coefficient of variation = 25.5 (Table 5.2).

In each case, the alpha coefficient was above the minimum of  $\alpha = 0.7$  recommended by Nunnally (1950). Furthermore, the inter-item correlations all exceeded the minimum of  $r = 0.3$  recommended by Kline (1986). The latter statistic is relevant since, as Cortina (1993) pointed out, an alpha coefficient can be high even when inter-correlations between the items are low, thus suggesting the possibility of multi-dimensionality.

The reason for calculating the alpha coefficient is to ensure that the scale shows a high level of consistency, i.e., that it 'holds together' as measuring a single entity, rather than comprising a series of loosely related – or even unrelated – items. The contribution of Cortina (1993) was to draw attention to the fact that, even if a scale does have an alpha coefficient of 0.7 or above, this does not ensure that only a *single* dimension is, in fact, being assessed. It is possible for what is thought to be a single scale to be assessing two or more separate, though related dimensions. If each item of a scale correlates with every other item of the same scale at a level of 0.3 or above, this is extremely unlikely to be the case.

The coefficients of variation (Yeomans, 1968) were all sufficiently high (in excess of 20.0) as to indicate an adequately wide spread of responses to the items that comprise the three scales, and that the degrees of variation are all of a similar order of magnitude as each other.

In any scale, if the coefficient of variation is much lower than 20, then the responses will tend to be ‘bunched’ together, with little difference between the highest and the lowest scores. It is also important that the coefficients of variation on all the scales that make up an instrument are more or less the same – otherwise the consequent ‘unevenness’ would result in some sets of data being ‘bunched’, with others having a wide distribution.

The items that comprise each of the scales are shown in Table 5.2. In interpreting this table, it is important to note that the items in each of the three scales that emerged have been drawn from the full questionnaire (Appendix 1). The way in which they are grouped is the result of the factor analysis.

**Table 5.2 – Items that comprise the three scales**

<b>Items that comprise the LCCI</b>					
<b>Scale 1 – Engaging with Others</b>					
<ul style="list-style-type: none"> <li>• Empowering others by trusting them to take decisions</li> <li>• Displaying a strong sense of loyalty to staff</li> <li>• Being active in developing staff strengths</li> <li>• Being willing to modify ideas after listening</li> <li>• Being able to inspire all staff such that they want to contribute fully</li> <li>• Making time for staff to discuss problems and issues, despite the busy schedule</li> <li>• Being active in supporting staff through coaching and mentoring</li> <li>• Involving all staff in determining how to achieve the vision</li> <li>• Maintaining a balance between the need for change and the need for stability</li> <li>• Being prepared to modify decisions</li> <li>• Using face-to-face communication</li> <li>• Being active in promoting the work or achievements of the team to the outside world</li> <li>• Being committed to developing competent leadership</li> <li>• Being able to think laterally</li> <li>• Involving all staff in developing the vision</li> <li>• Having staff at all levels who are prepared to stand up and be counted</li> </ul>					
16 items	$\alpha = .95$	Inter-item $r$ .54 - .65	Mean 4.62	Std. dev. 1.11	CoV 26.7

<b>Visionary Leadership</b>					
<ul style="list-style-type: none"> <li>• Inspiring external stakeholders by its passion and determination</li> <li>• Being sensitive to agenda of a wide range of external stakeholders</li> <li>• Being strategic in its thinking</li> <li>• Articulating clearly defined standards or criteria for staff to achieve</li> <li>• Having clear boundaries for people's responsibilities</li> <li>• Having clear vision of what the team is aiming for</li> <li>• Encouraging staff at all levels to think strategically rather than in the short term</li> </ul>					
7 items	$\alpha = .90$	Inter-item <i>r</i> .43 - .68	Mean 4.44	Std. dev. 0.98	CoV 21.6

<b>Leadership Capabilities</b>					
<ul style="list-style-type: none"> <li>• Striving to achieve goals and targets, within agreed time-scales and in accordance with standards and other criteria set</li> <li>• Being able to make sense of different types of information so as to make meaningful comparisons and/or to identify patterns and trends</li> <li>• Understanding and using the team's overall strategy and purpose to achieve goals and objectives</li> <li>• Understanding and making effective use of the team's structures and systems, planning and decision making, to achieve goals</li> <li>• Ensuring that team members and others are clear about the nature of agreed activities, goals and/or targets, and the criteria for success</li> <li>• Being committed to the achievement and maintenance of high standards, constantly seeking improvements in service delivery and quality outcomes</li> <li>• Establishing, maintaining and updating procedures for ensuring quality</li> <li>• Establishing agreed standards of performance</li> <li>• Managing the team's budget, based on accurate information and realistic projects</li> <li>• Making sound judgements, based on a wide range of factual information, organisational values and constraints, and the views of team members, users and carers</li> <li>• Being able to manage time such that goals are achieved efficiently and effectively</li> <li>• Having developed well thought out systems and procedures which support the effective use of resources</li> <li>• Prioritising the critical goals and milestones for achieving team development</li> <li>• Planning projects on the basis of specified goals/targets and deadlines, and effective use of resources</li> </ul>					
14 items	$\alpha = .94$	Inter-item <i>r</i> .36 - .73	Mean 4.66	Std. dev. 1.09	CoV 25.5

## Reliability of the LCCI

- **Leadership scales**

*Internal consistency:*

As noted above, the internal consistency of the three LCCI scales is high ( $\alpha = .90 - .97$ ; inter-item  $r \geq .36$ ).

In other words, each of the scales shows a high level of internal consistency, well above the 0.7 criterion, while the inter-item correlation coefficients are above the 0.3 criterion. The coefficients of variation indicate that the responses are distributed widely, rather than 'bunched', and are of the same order of magnitude as each other.

*Test-retest reliability:*

In order to assess its test-retest reliability, the instrument was administered a second time, after an interval of 12-18 months. The mean and standard deviation differences between Time 1 and Time 2 scores, and test-retest correlations are presented in Table 5.3.

What Table 5.3 shows is that the ratings of the three different aspects made by individuals on the LCCI on the first occasion (Time 1) were significantly correlated with those made by the same individuals when the instrument was administered a second time (Time 2). This information is shown as test-retest correlations of between  $r = .44$  and  $.62$ , in the extreme right hand column. It also shows (column 4) that the mean ratings on the 'Engaging with Others' scale were significantly lower at Time 2.

**Table 5.3 – Means and standard deviations (SD), differences (using t-tests) between Time 1 and Time 2 scores, and test-retest correlations, for Scale 1: Engaging with Others, Scale 2: Visionary Leadership, and Scale 3: Leadership Capabilities**

Scale		N	Mean	SD	Difference <i>p</i>	Test-retest <i>r</i>
Scale 1: Engaging with Others	Test	172	4.65	0.79	.000	0.62***
	Re-test	172	4.43	0.92		
Scale 2: Visionary Leadership	Test	174	4.40	0.79	ns	0.44***
	Re-test	174	4.35	0.89		
Scale 3: Leadership Capabilities	Test	174	4.60	0.79	ns	0.49***
	Re-test	174	4.50	0.81		

\*\*\* denotes  $p < .001$

- **Attitudes and Well-being**

The same statistics were also calculated for each of the facets of attitudes to work and well-being at work (Table 5.4).

In the case of 'Scale 1: Engaging with Others', the mean score was significantly lower at retest ( $p < .000$ ), and the test-retest coefficient was  $r = .62$  ( $p < .001$ ). The reduced mean score at Time 2 is consistent with the results for the other two leadership scores, and with scores on the attitudes to work and well-being at work *facets*, with the exception of 'A low level of job-related stress', where the mean score at Time 2 was significantly higher than at Time 1 ( $p = .019$ ).

In other words, ratings of the extent to which there was evidence of 'Engaging with Others' was lower at Time 2 than at Time 1. It is not clear why such differences should emerge.

*Test-retest reliability:*

The test-retest coefficient for 'Scale 1: Engaging with Others' compares favourably with the different *facets* scores, while the coefficients for 'Scale 2: Visionary Leadership' ( $r = .44$ ,  $p < .001$ ) and for 'Scale 3: Leadership Capabilities' ( $r = .49$ ,  $p < .001$ ) were of the same order of magnitude or slightly higher than the facet scores.

Overall, then, the correlation coefficients indicate that each of the leadership scales and each of the items measuring attitudes to work, or well-being at work, shows a high level of reliability.

It is not clear why there were differences between ratings at Time 1 and Time 2, nor why, with the exception of 'reduces job-related stress' and 'a high sense of fulfilment amongst staff', the ratings are lower at Time 2.

**Table 5.4 – Means and standard deviations, differences (using t-tests) between Time 1 and Time 2 scores, and test-retest correlations, for each of the facets of Attitude to Work and Well-being at Work**

Scale		N	Mean	SD	Difference <i>p</i>	Test-retest <i>r</i>
<b>Attitudes to Work</b>						
A high level of job satisfaction	Test	165	4.58	1.25	.049	.38***
	Retest		4.36	1.23		
A high level of motivation to achieve	Test	171	4.80	1.03	.04	.43***
	Retest		4.61	1.20		
Staff who are motivated to achieve beyond their expectations	Test	143	4.50	1.13	ns	.45***
	Retest		4.42	1.12		
A strong sense of job commitment	Test	168	5.11	0.84	.000	.38***
	Retest		4.71	1.02		
A strong sense of commitment to the organisation	Test	168	4.52	1.07	.05	.37***
	Retest		4.33	1.16		
<b>Well-being at Work</b>						
A high sense of fulfilment among staff	Test	170	4.15	1.26	ns	.47***
	Retest		4.26	1.27		
A high level of self esteem among staff	Test	172	4.34	1.36	ns	.39***
	Retest		4.31	1.38		
A high level of self-confidence	Test	165	4.87	0.95	.000	.39***
	Retest		4.53	1.10		
A low level of job-related stress	Test	166	3.21	1.44	.019	.39***
	Retest		3.54	1.74		
A low level of job-related emotional exhaustion	Test	161	4.38	1.42	.008	.33***
	Retest		4.32	1.50		
A strong sense of team spirit	Test	171	5.01	1.22	.021	.49***
	Retest		4.80	1.18		
A strong sense of team effectiveness	Test	172	4.81	1.16	.001	.33***
	Retest		4.47	1.26		

\*\*\* denotes  $p < .000$

- **Relationship between leadership scales**

Product-moment correlations were calculated between each of the three leadership scales and the twelve impact measures. Statistically significant relationships were detected between the leadership scales ( $r \geq 0.82$ ) (Table 5.5), suggesting a high level of co-linearity.

**Table 5.5 – Correlations between Leadership Scales ( $n = 731$ )**

<b>Scale</b>	<b>Scale 2: Visionary Leadership</b>	<b>Scale 3: Leadership Capability</b>
Scale 1: Engaging with Others	.82***	.88***
Scale 2: Visionary Leadership		.91***

\*\*\* denotes  $p < .001$

- **Relationships between Leadership and Attitudes and Well-being**
- ***Product-moment correlations***

For the 731 individuals who completed the LCCI, the inter-correlations between the twelve impact measures ranged from  $r = 0.25$  ('Staff who are motivated to achieve beyond their expectations' x 'A low level of job-related emotional exhaustion') to  $r = 0.75$  ('A high level of self esteem among staff' and 'A high sense of fulfilment among staff') ( $p < .01$  in each case).

In order to examine the relationship between leadership quality and different aspects of staff attitudes to work and well-being at work, product moment correlation coefficients were calculated.

The correlations between scores on the leadership scales and the impact measures range from  $r = 0.41$  ('Scale 3: Leadership Capability' x reduced stress) to  $r = 0.75$  ('Scale 3: Leadership Capability' x sense of team effectiveness) (Table 4.5).



**Table 5.6 – Range of correlations between scores on the leadership scales and the impact measures (n = 731)**

<b>Scale</b>	<b>Lowest r</b>	<b>Highest r</b>
Scale 1: Engaging with Others	A low level of job-related stress 0.43***	A strong sense of team effectiveness 0.74***
Scale 2: Visionary Leadership	A low level of job-related emotional exhaustion 0.43***	A high level of motivation to achieve 0.68***
Scale 3: Leadership Capability	A low level of job-related stress 0.41***	A strong sense of team effectiveness 0.75***

\*\* denotes  $p < .001$

It is recognised that collecting more than one set of data from the same instrument or from different instruments at the same session is open to the criticism that correlation coefficients may be inflated, owing to common method variance (e.g., Patterson, *et al.*, 2004). Conversely, it has been argued by Spector (2006) that the evidence for this is by no means unequivocal.

Patterson *et al.* sought to correct for common variance error by splitting the sample (in this case hospital trusts) into two parts and correlating the independent variable data for sub-set 1 with the dependent variable data for sub-set 2. However, following their analyses they concluded that there was no significant difference between the corrected and uncorrected results.

- **Stepwise multiple regressions**

In order to examine further these relationships, stepwise multiple regression analyses were conducted, with the three leadership scales as independent variables and the twelve person-related dependent variables (*facets*), with missing scores being replaced by means. As shown in Table 5.7, 'Scale 1: Engaging with Others', was significantly related to each of the five attitudes to work items and each of the seven facets of well-being at work items.

'Scale 2: Visionary Leadership' was significantly related to two facets of attitudes to work ('A high level of motivation to achieve' and 'A strong sense of team effectiveness'), and to four aspects of well-being at work ('A high sense of fulfilment among staff' and 'A high level of self esteem among staff') and ('A low level of job-related stress' and 'A low level of job-related emotional exhaustion').

The attitudes to work of 'A high level of job satisfaction', 'A high level of motivation to achieve' and 'Staff who are motivated to achieve beyond their

expectations' were significantly related to 'Scale 3: Leadership Capabilities', as was one aspect of well-being at work, 'A high level of self-confidence'.

**Table 5.7 – Multiple regressions analyses for all subjects in relation to each of the Attitudes to Work and Well-being at Work items (beta coefficients) (n = 731)**

<b>Impact measure / Leadership scale</b>	<b>Scale 1: Engaging with Others</b>	<b>Scale 2: Visionary Leadership</b>	<b>Scale 3: Leadership Capabilities</b>
<b>Attitudes to Work</b>			
A high level of job satisfaction	.56	-	.17
A high level of motivation to achieve	.41	.18	.18
Staff who are motivated to achieve beyond their expectations	.46	-	.21
A strong sense of job commitment	.65	-	-
A strong sense of commitment to the organisation	.65	-	-
<b>Well-being at Work</b>			
A high sense of fulfilment among staff	.48	.28	-
A high level of self esteem among staff	.46	.23	-
A high level of self-confidence	.61	-	.12
A low level of job-related stress	.22	.24	-
A low level of job-related emotional exhaustion	.34	.14	-
A strong sense of team spirit	.70	-	-
A strong sense of team effectiveness	.26	.18	.33

Since at least six of these items (motivation; motivation to achieve beyond own expectations; job commitment, organisational commitment; job satisfaction; reduced stress) have been shown to be predicted by effective leadership behaviour (e.g., Alban-Metcalfe & Alimo-Metcalfe, 2000a, b; Bass, 1998; Borrill *et al.*, 2005a&b; Parker *et al.*, 2003; Patterson *et al.*, 2004), these results provide evidence of the concurrent validity of the LCCI among this population.

What these results offer, then, is support for the conclusion that the LCCI shows a significant level of concurrent validity. That is to say, ratings of

leadership are positively associated with what one would expect them to be associated with, namely positive attitudes to work, and a sense of well-being at work. In particular, 'Engaging with Others' is a significant predictor of each of the twelve criterion measures (the *facets*), while visionary leadership behaviour is a significant predictor of six, and leadership capabilities a significant predictor of five.

- ***Hierarchical multiple regressions***

In order to be assured that the relationships between leadership quality and person-related dependent variables (*facets*) could not be attributed to contextual factors, hierarchical multiple regression analyses were performed with each of the *facets* as the dependent variable and each of the leadership scales in turn and all the contextual factors as independent variables (see Appendix 4). Here, calculations were based on the responses of individual team members ( $n = 420$ ).

The results suggest that, only in the case of ratings of 'reduced job-related stress', do any of the context factors affect the relationship between scores for a facet and those for a leadership quality. Thus, in the relationship between 'stress' and Scale 1: 'Engaging with Others', gate-keeping had the effect of reducing job-related stress, while greater medical cover tended to have the effect of increasing it. A similar patterns emerged when Scale 2: 'Visionary Leadership' was an independent variable, except that amount of service cover tended also to be associated with increased stress. For relationships involving Scale 3: 'Leadership Capabilities', increased gate-keeping was associated with decreased stress, and amount of service cover with increased stress.

However, in all cases, quality of leadership as measured by each of the three scales had much the greatest impact on each of the facets. Thus, where Scale 1 was one of the independent variables the beta coefficients linking it with the relevant facet ranged from 0.39 for stress to 0.68 for job satisfaction and for motivation. For Scale 2 the range was from 0.42 for stress to 0.63 for motivation, for Scale 3 from 0.40 for stress to 0.67 for motivation ( $p < .001$ , in all cases).

It is evident, then, that, while certain contextual variables do have a statistically significant effect on certain facets of attitude to work and sense of well-being at work, staff ratings on these facets are predominantly affected by the quality of leadership behaviour.

Formally, it may be concluded that the quality of leadership of CRTs is positively associated with staff attitudes to work and well-being at work, and that Hypothesis 2 is supported.

In other words, the higher the quality of the leadership of the team, the more positive were the staff's attitudes to work, and the greater their sense of well-being at work.

## Relationship between Quality of Leadership and Team Performance

### Hypothesis 3 and Hypothesis 4

These hypotheses state that the quality of leadership quality of CRTs is positively associated with a higher *ratio* of the number of assessments made by the team in relation to the number of referrals for in-patient care (Hypothesis 3), and that the quality of leadership of CRTs is positively associated with a *change* in the ratio of the number of assessments made by the team in relation to number of referrals for in-patient care, over a 12-month period (Hypothesis 4).

In other words, Hypothesis 3 is concerned with the *average* of the ratio of assessments to referrals over the year, whereas Hypothesis 4 addresses the issue of whether the ratio of assessments to referrals *changes* during the 12 month period.

Both hypotheses were tested both at the team level, using analysis of variance, and at the individual team member level, using product-moment correlations and hierarchical multiple regression analysis.

- ***Analysis of variance***

At a *team level*, teams were divided into 3 categories: high performing; moderately performing; low performing, with reference (a) to the ratio of assessment to referrals made to in-patient care ('ratio'), and (b) to a reduction in assessments to referrals made to in-patient care over a 12-month period ('change').

One-way analyses of variance, followed by Tukey HSD test, were applied to the data. The interaction effect reached the  $p \leq .05$  level of significance only in the case of the ratio of assessment to referrals for in-patient care ('ratio'). As shown in Table 4.6, application of Tukey HSD test suggests that the mean scores for 'Scale 1: Engaging with Others' for the high performing team were significantly higher than for those for both the moderately performing team ( $p = 0.020$ ) and the low performing team ( $p = 0.037$ ). There was, however, no evidence of the effect of 'Scale 2: Visionary Leadership' or of 'Scale 3: Leadership Capabilities' on the ratio of assessments to referrals for in-patient care.

There was, however, no evidence of a significant leadership quality-effect in the 'change' scores. Although the scores for 'Scale 1: Engaging with Others' were in the predicted direction, the  $F$  score was not statistically significant ( $p = .051$ ).

**Table 5.8 – Means and standard deviation of leadership scores in relation to (a) the ratio of assessments to referrals for admission to in-patient care ('Ratio'), and (b) any reduction in the ratio over a 12-month period ('Change'), for high performing, moderately performing and poorly performing teams.**

<b>Ratio (Assessments/ referrals)</b>	Group	Mean score	S.D.	N of ratings	Difference (Tukey's test)
Scale 1: Engaging with Others  <i>F</i> <sub>2,418</sub> = 4.29, <i>p</i> = .014	High	4.77	0.80	157	High vs. Moderate <i>p</i> = 0.037
	Moderate	4.75	0.69	145	
	Low	4.51	0.86	119	High vs. Low <i>p</i> = 0.020
Scale 2: Visionary Leadership  <i>F</i> <sub>2,418</sub> = 0.86, ns	High	4.54	0.84	157	ns
	Moderate	4.48	0.79	145	
	Low	4.41	0.84	119	
Scale 3: Leadership Capabilities  <i>F</i> <sub>2,419</sub> = 2.80, ns	High	4.75	0.73	157	ns
	Moderate	4.66	0.68	145	
	Low	4.54	0.78	120	
<b>Change (Change in ratio of assessments/ referrals)</b>	Group	Mean score	S.D.	N of ratings	Difference (Tukey's test)
Scale 1: Engaging with Others  <i>F</i> <sub>2,355</sub> = 3.00, <i>p</i> = .051	High	4.88	0.80	81	ns
	Moderate	4.65	0.72	193	
	Low	4.64	0.83	84	
Scale 2: Visionary Leadership  <i>F</i> <sub>2,355</sub> = 2.33, ns	High	4.54	0.84	81	ns
	Moderate	4.48	0.79	193	
	Low	4.41	0.84	84	
Scale 3: Leadership Capabilities  <i>F</i> <sub>2,355</sub> = 1.52, ns	High	4.75	0.73	81	ns
	Moderate	4.66	0.68	193	
	Low	4.54	0.78	84	

In summary, what these results suggest is that teams which are characterised by higher levels of engagement were those that were more successful in ensuring that service users were treated in their own home, rather than being admitted for in-patient care. Using this criterion, there were, however, no differences between teams in relation to the extent to which the leadership was perceived as visionary, nor the extent to which they were seen to be competent.

Also, none of the measures of leadership quality were linked to changes in the assessment-to-admissions ratio.

- **Product-moment correlations**

At the level of *individual team members*, product-moment correlations were calculated between their leadership quality ratings and (a) the 'ratio' score ( $n = 420$ ), and (b) the 'change' score for their team ( $n = 357$ ) (Table 5.9).

**Table 5.9 – Product-moment correlations between leadership scores and (a) the ratio of assessments to referrals for admission to in-patient care ('Ratio') ( $n = 420$ ), and (b) any reduction in the ratio over a 12-month period ('Change') ( $n = 357$ ).**

VARIABLES	Ratio	Change
Scale 1: Engaging with Others	-.08	.05
Scale 2: Visionary Leadership	-.03	.07
Scale 3: Leadership Capabilities	-.05	-.01

With the exception of 'Scale 3' x 'change', the coefficients are in the predicted direction, but none reached the 5 per cent level of statistical significance.

In other words, there was no evidence to support the suggestion that individual team members' perceptions of the quality of the leadership of their team were correlated with their team achieving either of the goals relating to treating service users in the community.

- **Hierarchical multiple regressions**

Hierarchical multiple regression analyses were performed on the same data (Table 5.10). The purpose of this was to determine whether any relationships could be detected between leadership behaviour and the same two criteria, when the effect of the other variables of context and aspects of attitudes to, and well-being at, work are taken into account. Here, only the results for Scale 1 are presented; similar results were obtained for Scales 2 and 3.

**Table 5.10 – Hierarchical multiple regression analyses for ‘Ratio’ ( $n = 420$ ), and (b) ‘Change, against Contextual variables ( $n = 357$ ), ‘Scale 1: Engaging with Others’, job satisfaction, motivation to achieve, motivation to achieve beyond expectations, job commitment, organisational commitment, and reduced stress (beta values).**

VARIABLES	Ratio	Change
Psychosis	.06	-.01
MINI	-.10	-.07
Alternatives	-.22***	.28***
Team age	.20**	.07
Staff/case	-.28***	.24***
Gate-keeping	-.23***	-.16*
Medical cover	.27***	-.06
Multi-disciplinary	.18**	-.43***
Service cover	-.21***	-.09
Scale 1	-.10	-.00
Job satisfaction	.06	-.00
Motivation to achieve	.08	-.02
Motivation beyond expectations	.06	-.01
Job commitment	.08	.02
Organisational commitment	.06	-.04
Reduced stress	.06	-.12

\* –  $p \leq .05$     \*\* –  $p \leq .01$     \*\*\* –  $p \leq .001$

The results for the *ratio* of assessments to in-patient admissions results appear to suggest: -

- the proportion of service users who present symptoms of psychosis, does not have a significant impact on the assessment/admissions ratio;
- that the MINI score for the area in which the team is located does not affect the assessment/admissions ratio;
- that the availability of alternatives to in-patient provision has a *positive* effect on reducing the assessment/admissions ratio ( $p < .001$ );
- that the younger the team, the *lower* the proportion of service users admitted to in-patient care ( $p < .001$ );
- that having more team members dealing with a given case, has a *positive* effect on reducing the assessment/admissions ratio ( $p < .001$ );
- that the greater the gate-keeping control that a team has, the more *positive* the effect on reducing the assessment/admissions ratio ( $p < .001$ );
- that the greater the extent of psychiatrist involvement, the *higher* the proportion of service users being admitted to in-patient care ( $p < .001$ );
- that the greater the number of different professions represented within a team, the *higher* the proportion of service users admitted to in-patient care ( $p < .001$ );
- that the greater the extent of service cover, the *lower* the proportion of service users admitted to in-patient care ( $p < .001$ );

- that the quality of the leadership, did not have a significant impact on the proportion of service users admitted to in-patient care;
- that the six facets of attitude to work or well-being at work do not, on their own, affect the proportion of service users admitted to in-patient care.

Here, what emerges is evidence that the proportion of service users admitted to in-patient care is affected to a significant extent by seven of the contextual factors that have been measured, five in a positive and two in a negative direction. Some of these (the number of alternatives to in-patient provision that are available; the more team members that deal with a given case; the greater the gate-keeping control; the greater the extent of service cover) have a *positive* effect on the assessment/admission ratio. On the other hand, others (the number of years that the team has been established; the greater the extent of psychiatrist involvement; the greater the number of professions represented in the team) appear to have a *negative* effect on the assessment/admission ratio. The proportion of service users who present symptoms of psychosis, and the MINI score for the locality, do not appear to impact significantly on the ratio; nor does either leadership quality or the six facets of staff attitudes to work or their perceptions of well-being at work.

A largely similar picture emerged among the relationships with *change* in ratio scores. The only differences were: -

- the age of the team no longer continued to have a significant effect;
- that the greater the gate-keeping control a team has, the lower the effect on changing the admissions/referrals ratio ( $p < .05$ );
- that the extent of psychiatrist involvement no longer continued to have a significant effect;
- that the extent of service cover no longer continued to have a significant effect.

All this information is of signal importance in continuing to guide planning into the nature and extent of crisis resolution and home treatment services. In relation to the thesis of the present study, however, the super-ordinate issue is the great extent to which factors that are largely, if not wholly, outside the control of the leadership of a team can have a profound effect both on proportion of service users admitted to in-patient care, and on any changes in that ratio.

Formally, therefore, there is support at a team level for Hypothesis 3, but Hypothesis 4 must be rejected.

What emerges, then, is

- 1) that there is some support for the suggestion that quality of leadership (in this case, only measured in terms of 'engaging with others') is related to performance measured at the team level, but
- (2) that this is not supported at the level of individual team members.



## Hypothesis 5 and Hypothesis 6

As argued above, the effectiveness of a team, with reference to either of the above criteria, is a measure of its 'productivity'. Furthermore, use of this metric, which is the most commonly used criterion for assessing organisational performance, enables direct comparisons to be made between this and other relevant studies.

Hypothesis 5 states that the quality of leadership of CRTs is positively associated with higher *productivity* which is reflected in a higher ratio of assessments made by the team to the number of referrals to in-patient care, as a function of the ratio of staff to service users.

Hypothesis 6 states that the quality of leadership of CRTs is positively associated with a *change in productivity*, as measured by an increase in the ratio of the number of assessments made by the team in relation to number of referrals to in-patient care, over a 12-month period, as a function of the ratio of staff to service users.

As with the 'ratio' scores, '*productivity*' was calculated on the basis of the average over a 12-month period; a *low* score indicates fewer in-patient referrals per assessment, in proportion to the ratio of staff-to-users. Similarly, '*change in productivity*' was based on changes over a 12-month period;

In calculating reduction in ratio of assessment to admissions over a 12-month period; a *high* score indicates a decrease in the ratio of in-patients admissions to assessments, as a function of staff-to-users ratio.

In order to examine relationships involving the 'productivity' and 'change in productivity' of team members, product-moment correlations were calculated and multiple regression analyses undertaken. In addition, the data were subject to structural equation modelling.

- ***Product-moment correlations***

Product-moment correlation coefficients were calculated between individuals' scores on each of the three leadership scales and the two measures of productivity, (a) in relation to 'productivity', and (b) in relation to 'change in productivity' (Table 5.11).

**Table 5.11 – Product-moment correlations between leadership scores and (a) 'Productivity' (n = 420), and (b) 'Change in productivity' (n = 357)**

VARIABLES	Productivity	Change in productivity
Scale 1: Engaging with Others	-.05	.05
Scale 2: Visionary Leadership	-.02	.02
Scale 3: Leadership Capabilities	-.03	.06

In other words, no simple relationships exist between any of the three measures of leadership quality and either productivity or change in productivity.

The results indicated that none of the coefficients was statistically significant.

- **Hierarchical multiple regressions**

Hierarchical multiple regression analyses were performed, in this case with the leadership scales, six facets of attitudes to work or well-being at work, and contextual factors as independent variables, and (a) to the proportion of referrals made to in-patient care, in relation to the ratio of assessments made to number of team members ('productivity') and (b) to a reduction in the proportion of referrals to in-patient care over a 12-month period, in relation to the ratio of assessments made to number of team members as the dependent variable ('change in productivity'). The six facets selected were job satisfaction, motivation to achieve, motivation to achieve beyond expectations, job commitment, organisational commitment, and reduced stress, each of which has been used in comparable studies (Table 5.12).

**Table 5.12 – Hierarchical multiple regression analyses for (a) 'Productivity' ( $n = 420$ ), and (b) 'Change in Productivity' ( $n = 357$ ), against Contextual variables, 'Scale 1: Engaging with Others', job satisfaction, motivation to achieve, motivation to achieve beyond expectations, job commitment, organisational commitment, and reduced stress (beta values).**

VARIABLES	Productivity	Change in productivity
Psychosis	.18***	-.17**
MINI	-.08	-.21***
Alternatives	-.12**	.47***
Team age	.36***	-.02
Staff/case	-.51***	.32***
Gate-keeping	-.22***	-.04
Medical cover	.33***	.12*
Multi-disciplinary	-.00	-.33***
Service cover	-.25***	-.04
Scale 1	-.18*	-.05
Job satisfaction	.05	-.00
Motivation to achieve	.14	.02
Motivation beyond expectations	.01	-.02
Job commitment	-.02	.03
Organisational commitment	-.01	.01
Reduced stress	.02	-.17**

\* –  $p \leq .05$     \*\* –  $p \leq .01$     \*\*\* –  $p \leq .001$

The value of using this technique is that significant relationships can be detected when the 'contaminating' effects of other variables have been removed.

Thus, as far as the *productivity* of the teams is concerned, these results appear to suggest: -

- that the higher the proportion of service users who present symptoms of psychosis, the lower the productivity ( $p < .001$ );
- that the MINI score for the area in which the team is located does not affect productivity;
- that the availability of alternatives to in-patient provision has a positive effect on productivity ( $p < .01$ );
- that the younger the team, the higher its productivity ( $p < .001$ );
- that the more team members dealing with a given case, the higher the productivity ( $p < .001$ );
- that the more gate-keeping control that a team has, the higher the productivity ( $p < .001$ );
- that the greater the extent of psychiatrist involvement, the higher the productivity ( $p < .001$ );
- that the number of different professions represented within the team does not affect productivity;
- that the greater the extent of service cover, the higher the productivity ( $p < .001$ );
- that the better the quality of the leadership, measured in terms of engaging with staff, the higher the productivity ( $p < .05$ );
- that the six facets of attitude to work or well-being at work do not, on their own, affect productivity.

Here, what emerges is evidence that productivity is affected to a significant extent by seven of the contextual factors that have been measured. Some of these (the number of alternatives to in-patient provision that are available; the more team members that deal with a given case; the greater the gate-keeping control; the greater the extent of psychiatrist involvement; the greater the extent of service cover) have a positive effect on productivity. At the same time, others (the higher the proportion of service users who present symptoms of psychosis; the number of years that the team has been established) appear to have negative effect on productivity.

All this information is of signal importance in continuing to guide the nature and extent of crisis resolution and home treatment services. In relation to the thesis of the present study, however, the super-ordinate issue is the extent to which factors that are largely, if not wholly, outside the control of the leadership of a team can have a profound effect on its level of productivity.

Conversely, it is interesting to note that, in spite of the significant, and in some cases, profound influence of these factors, quality of leadership does emerge as having a statistically significant effect on productivity. It is also interesting

to note, in terms of the nature of such leadership, that it is exclusively of the kind that reflects engagement with staff, as assessed by Scale 1.

Analysis of the results in terms of *change in productivity* appears to suggest: -

- that the higher the proportion of service users who present symptoms of psychosis, the lower the change in productivity ( $p < .01$ );
- that the higher MINI score for the area in which the team is located, the lower the change in productivity ( $p < .001$ );
- that the availability of alternatives to in-patient provision has a positive effect on change in productivity ( $p < .001$ );
- that the age of the team does not affect changes in productivity;
- that the more team members dealing with a given case, the higher the change in productivity ( $p < .001$ );
- that gate-keeping control does not affect change in productivity;
- that the greater the extent of psychiatrist involvement, the lower the change in productivity ( $p < .05$ );
- that the fewer number of different professions represented within the team the higher the change in productivity ( $p < .001$ );
- that the amount of service cover does not affect change in productivity;
- that quality of the leadership, measured in terms of engaging with staff, does not affect change in productivity;
- that five of the six facets of attitude to work or well-being at work do not, on their own, affect change in productivity;
- that self-perceptions of a reduced level of job-related stress is associated with lower levels of change in productivity ( $p < .01$ ).

Here, contextual factors emerge as having a significant effect, though the pattern of relationships is slightly different. Thus, change in productivity is positively associated with greater number of alternatives to in-patient care, greater number of team members dealing with a given case, and greater the extent of psychiatrist involvement. On the other hand, a number of contextual factors appear to have a negative effect. These are: - the proportion of users presenting symptoms of psychosis (as with productivity), the MINI for the area, and greater number of different professions represented within the team. Neither the age of the team, nor greater gate-keeping control, nor extent of service cover, had a significant impact.

At the same time, none of the leadership scales was significantly linked to change in productivity, though, counter-intuitively, 'reduced job-related stress' was significantly negatively with change.

What emerges, then, is

- (1) that the leadership behaviour of 'engaging with others' is positively associated with productivity – the more engaging the leadership, the greater the productivity;
- (2) that, this notwithstanding, contextual factors, notably, the more staff working on each case, and the amount of service cover provided, and

- the extent to which the team acts as a 'gate-keeper', has a *greater* effect on productivity;
- (3) that the age of the team, and the amount of medical cover, has a *negative* effect on productivity.

- ***Structural equation modelling***

In order to examine the relationships between the various independent variables (leadership quality and contextual factors), the person-related dependent variables (facets of attitudes to work and well-being at work), and organisational performance (productivity and change in productivity), a series of structural equation models were developed and tested.

A model that presents inter-relationships significant at or beyond the 5 per cent of significance is presented in Figure 5.1.

Of particular relevance to the present study, significant links were found to exist between ratings on 'Scale 1: Engaging with Others', the seven contextual variables that were assessed, four person-related dependent variables (JOBSAT, 'job satisfaction'; JOBCOMM, 'job commitment'; STRESS, 'reduced job-related stress'; ACHIEVE, 'motivation to achieve'), and two of the measures of organisational performance (ASSESS\_C, 'productivity'; ADMISS\_C, 'change in productivity').

As predicted, Scale 1 was a significant predictor of 'productivity', and of 'job satisfaction', 'job commitment', 'reduced job-related stress' and 'motivation to achieve'. Counter-intuitively, however, 'motivation to achieve' was negatively related to 'productivity', and as was 'reduced job-related stress' in relation to 'change in productivity'. However, all the established links can only be regarded as accounting for 31 per cent of the variance in 'productivity' scores, and 56 per cent of variance in 'change in productivity' scores.

It was not possible to construct a model for either Scale 2 or Scale 3.

Formally, then, there is support for Hypothesis 5, though only in the case of 'Scale 1 – Engaging with Others'. Using this scale to assess leadership behaviour, the greater the quality of the leadership of the team, the higher was its level of productivity.

However, Hypothesis 6, concerned with a link between quality of leadership and increase in productivity over time, must be rejected.

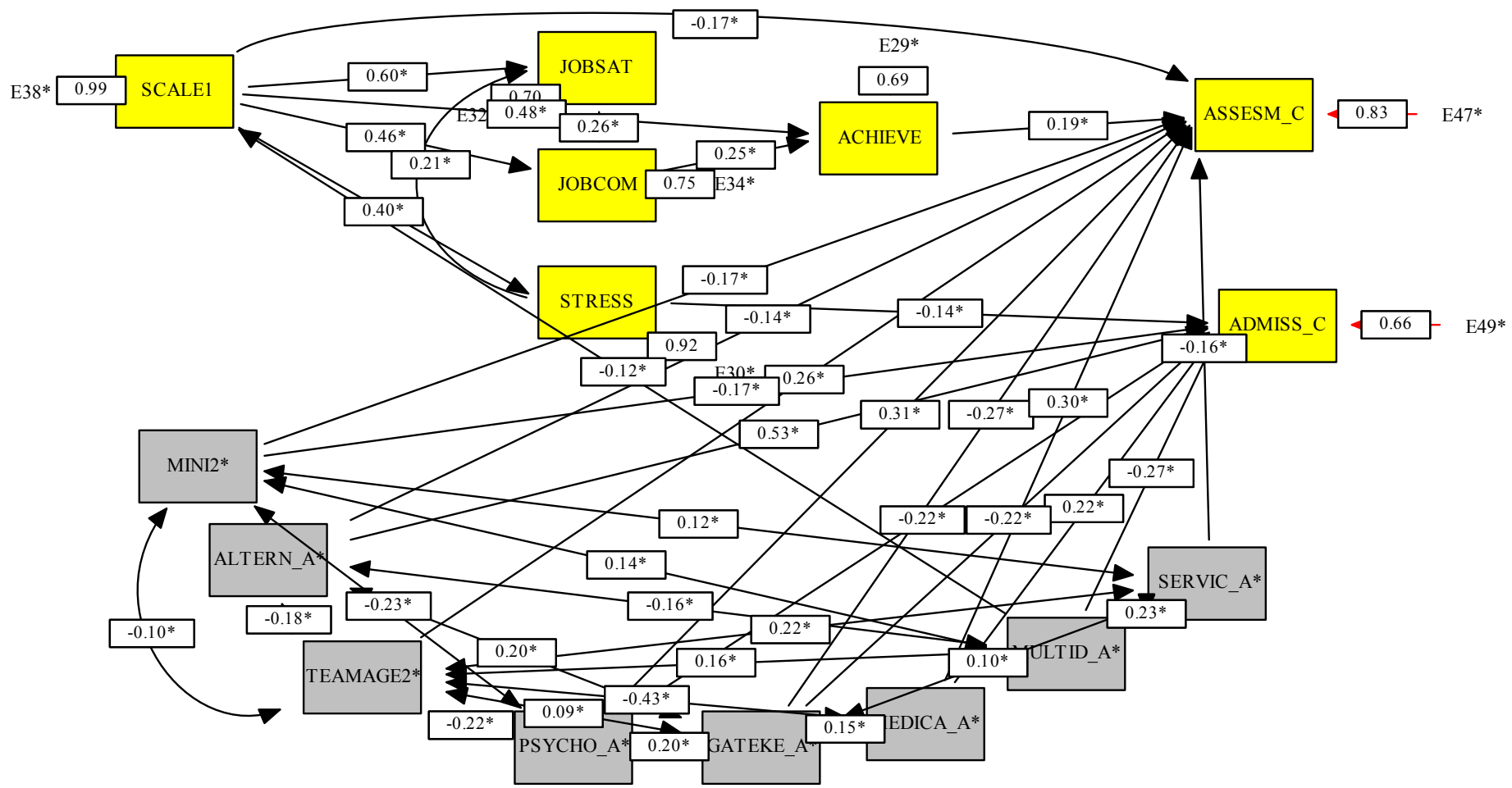


Figure 5.1: EQS 6 realworld model6d after wald.eds Chi Sq.=155.30 P=0.00 CFI=0.96 RMSEA=0.05

As noted in Section 4, the value of structural equation modelling lies in its capacity to identify likely cause-effect relationships. In this case, what the pattern of relationships that emerges

- (1) confirms that 'engaging with others' is significantly linked to productivity;
- (2) indicates that the contextual factors that were measured are also significantly linked to productivity; and
- (3) in contrast to what might be expected, 'motivation to achieve' was significantly linked to lower productivity.

## **Relationship between Quality of Leadership and Change Management**

### **Hypothesis 7**

Hypothesis 7 states that a more enabling or transformational style of leadership will be associated with a more transformational approach to managing change.

### **Analysing change**

In order to gain an understanding of the change management approaches used by participating CRTs we compiled a semi-structured questionnaire based on the work by Iles and Sutherland (2001). The questionnaire covered several key areas relating to change management within the CRT. These included change:

- Involving internal staff
- To management or function of the team
- Involving external agents
- And the people involved with changes
- Involving senior and other team members
- Models applied when implementing changes
- Techniques used when implementing changes

The questionnaires were administered by a researcher and conducted over the telephone. The questionnaire was sent to the Team lead a week to ten days prior to interview. Each respondent was asked the same questions, which the interviewer recorded contemporaneously on the questionnaire. Interviews lasted between 40 minutes to one hour.

### **Findings**

A total of 52 telephone interviews were conducted with team leaders using the devised semi-structured questionnaire. Responses to open-ended questions were recorded by taking detailed notes. The themes and issues emerging

from these open-ended responses were identified, a coding frame developed and analysed using 'Nvivo'. We present the results from these telephone interviews focusing, for the most part, on the qualitative data gathered and the models and techniques used to implement change.

### *Team age*

Just over one-third of the teams had been set up within the last 2 years, while over 15 per cent had been in existence for three or more years. Team leads who participated in the change management interviews thus were attached to relatively new teams.

<b>Years in existence</b>	<b>% Teams</b>
1-2 years	36.5%
3-4 years	15.4%
5-6 years	5.8%
7-8 years	7.7%
9-10 years	7.7%

### **Setting up the team**

#### *Types of CRT implementation*

CRTs were brought into existence in a variety of different ways, revealing to some extent how policy implementation in the NHS takes place on the ground. There were those Trusts who started by forming a steering group of senior managers and directors, and other stakeholder groups with service users and carers. This steering group would be involved in the consultation process and discussions at the planning stage. A team lead would then be appointed to organise various activities from promoting the new service and recruitment of staff. At times this jeopardised other local mental health services, as staff from these would be attracted to the new CRT posts. At the same time beds in the inpatient ward would be closed and resources negotiated, frequently falling far short of what was promised.

One Trust fulfilled its obligation to introduce a CRT by assembling together various people and assigning them new roles. As one team lead described,

*'The trust decided to create CRTs by cobbling together various pieces [people]; it was a pragmatic approach that is typical of the NHS. I wouldn't have chosen to do this. People were just assigned new roles, so they ended up doing jobs that they had not intended to do, so there were problems in adjusting to this.'*



Having the commitment of the PCT made the process of implementation much easier. Introducing policy guidance in the first instance certainly laid the initial foundation for implementation, but this alone was not always enough. A stronger commitment by the PCT was necessary and often this came about if the need for the CRT service was recognised. Resources, albeit limited, would then be provided.

Three Trusts were keen to introduce an integrated crisis service where the inpatient ward and outpatient teams were combined. The rationale for this integrated approach was to ensure service users had continuity of care.

Time to set up a team ranged from a period of several months to a matter of weeks. One team lead had two weeks to put a CRT together. She started the same day as four other staff acquired from other mental health services that had just been reconfigured. With these staff came a caseload of 80 service users. Funding was available from the PCT but the start date had to be complied with. Consultation and communication with other staff and agencies had to be conducted very quickly.

Most Trusts had consulted with service users and carers during the initial period of team set-up. If time permitted this consultation was relatively extensive. If a team lead had a very tight start date or the team was already in existence then this initial service user consultation was either brief or nominal. Occasionally CRTs employed service users as employees to assist with this process of consultation.

### **Managing existing CRTs or HT teams**

Several team leads came a year or so after a CRT was set up. An initial task for one team lead was to settle existing conflicts between the CRT and the CMHT about best practice. In terms of building bridges, this team lead attended CMHT meetings, stepped outside the CRT's remit and did favours in order to create a positive perception of the CRT. This involved seeing how the CRT could support the CMHT by keeping clients out of hospital and taking on the more intense parts of the CMHT's work. It was this sort of flexible working that helped create positive relationships between the CRT and external agencies. Two team leads reported coming to CRTs that had been without a lead for a year or more which presented its own set of difficulties.

### **Importance of team leader skill and experience**

The majority of team leaders had the responsibility of putting their CRT together, and used the MHPIG as their main form of guidance. Occasionally the team lead would be required to write an operational policy or utilise one from another service. Often the team lead appointed would be a highly experienced practitioner and manager, with contacts and a great deal of knowledge of acute mental health services. This expertise and experience was critical to the success of bringing the team together.

One team lead started the process of introducing a CRT by conducting a 'gap analysis' as part of his planning and preparation. By doing this he discovered that existing providers – health, social and voluntary sector services – were

carrying out many referrals and assessments but little by way of treatment in the community for people in crisis. He made visits to other CRTs around the country looking at 'ways of working' and actively consulted with a range of stakeholders, including service users and carers. Once completed, this team lead presented plans of an ideal service to the PCT and the costs associated with it. These costs were considered too high and so a phased implementation model was introduced, prioritising certain aspects of the ideal model that were deemed most important.

## **Change involving internal staff**

### **Staffing the team**

Staff recruitment to new CRTs was sometimes a major difficulty, particularly when recruiting large numbers of people (up to 30 or more). In other situations, the team lead would have little control over staff selection. Staff mainly came from the existing CMHT, which in many cases created strained relationships between the CRT and the CMHT. Other staff came from the acute in-patient wards. Many team leads reported encountering great resistance from existing staff who opposed the proposed changes to their way of working. Some team leaders had problems with recruitment and retention, and they also had to deal with some staff that were disillusioned and then left the team.

Where teams did not have a dedicated consultant allocated to the team they had to share consultants with in-patient services or the CMHT. Where this was the case, it was seen as a big problem for the effective functioning of the team, particularly in performing its gate-keeping role.

Some teams fell short of having specialist staff such as social workers, a clinical psychologist and an occupational therapist, therefore limiting how multidisciplinary they were. The primary reason accounting for this deficiency was lack of resources and funding.

At times team leads appointed to an existing team would be obliged to make substantial changes to internal staff. Often this would challenge usual practice or ways of working among a variety of staff across a number of different agencies. One example of this was a team lead who carried out a predetermined decision to employ a carer support worker to work with families. The team had some reservations about this but realised the value of it following a series of discussions to work through the issues around this. This tactic by the team lead avoided directly imposing this decision on the team. Another task for the same team lead was to abolish permanent night staff as he had calculated that they were not financially viable. Also there was no real demand for night staff and alternatives to the CRT were available. Effectively, this removed an important part of the CRT function. Another problem for this team lead was inappropriate referrals from the A&E department. An attempt to resolve this included placing a CRT member in A&E to reduce inappropriate referrals. Despite meetings to agree this approach it was ultimately a failure,

as staff who stayed at A&E felt 'out on a limb' and staff at the A&E department were not keen on having CRT team members there.

Recruiting a full team was not always difficult. One team lead advertised for 14 F Grade nurses. He was able to recruit some excellent staff to the team, as the response was very good. These new recruits, however, had come from the acute inpatient ward, which created some friction between the two agencies. As this team moved into a second phase of recruiting 12 months later, the team lead advertised for a further 26 team members – Grades B and D. This created a new set of tensions within the team as each of the different grades was unclear about their roles.

The quality of staff recruited varied depending on the amount of time available to plan the new CRT. Many team leads felt fortunate they were able to recruit not only experienced and skilled staff, but highly committed to the purpose of the CRT.

Away days, one to ones and group meetings were often organised by team leads to address the changes teams underwent and the conflicts that subsequently arose. Many team leads considered it essential to deal with internal conflict rather than to avoid it. Handover meetings during the day were also considered a very useful way to discuss clients as well as any general difficulties that needed resolving.

Team leads would actively involve staff in creating a vision for the CRT and the direction it would take. One team lead regarded these tensions as a healthy part of team life. As he put it, "*not doing so would lead to a group [team] that was uncritical and unquestioning.*" A few team leads brought in external facilitators for away days and occasionally drug companies funded these given funding constraints.

Other examples of managing internal changes highlighted a problem some staff had in adjusting to their new role. A team lead described how one group of staff – whose background was in acute inpatient care – was unable to reconcile positive risk taking associated with working in the community. Eighteen months later many of these staff left the team. These issues were resolved for remaining staff by devoting a few days to team training to identify the team's vision and the expectations of service users, carers and staff. The product of this training was a values-based policy and implementation document to 'operationalise' the team's vision.

A sense of shared ownership within the team was considered important by most of the team leads interviewed. As one team lead described:

*'There are very strong characters in the team. They wouldn't react well to being told what to do. People need to feel that they contribute to change in order for change to work.'*

Changes for one team happened at very short notice. Decisions made by senior managers would circumvent any attempts by the team lead to manage

changes democratically within the team. Decisions by senior managers would very often be in relation to national targets and the pressure to meet these. The team would end up reacting to changes to implement them quickly. Teams under this sort of pressure would take longer to develop good relationships internally.

Supporting and being open towards staff was also considered important. As one team lead put it:

*'My approach is to be very open about things and above board. That way no one feels unfairly treated. I try to accommodate people's personal lives, because it is important to be supportive of people within the team.'*

In some situations the team lead would be left to deal with many of these conflicts unsupported and one team lead mentioned trying to obtain some internal supervision.

### **Changing shift patterns**

A few teams reported, as part of their new way of working, a change in shift patterns. Some teams, for example, introduced a night shift that was previously on-call. Often this had to be adjusted in some way to accommodate the needs of staff. Some would have long distances to travel to get to work. Twelve hour shift patterns were made available for staff who wanted them. These shifts were considered good for continuity of the service and communication.

### **Change to management or functioning of the team**

One team lead explained the different functions of the CRT prior to his arrival. The team had a liaison function that referred service users onto different agencies rather than doing the hands-on care. Other members of the team assumed the team lead would be in favour of this function. Instead he wanted to decrease it. Since his arrival, home visits have increased considerably. He has established regular contact with the wards through daily meetings and developed good reciprocal relationships. He effectively had to change the team's way of thinking to bring it in line with what a CRT is meant to do. Responsibility of clients has been transferred to team members and case management review meetings have been introduced to ensure team members are aware of the ward activities. Through this staff are said to have more ownership of their workload.

Other changes in functioning of the CRT concerned the role of the consultant psychiatrist. One team were keen to have the consultant in the CRT, but the consultants in the Trust were opposed to this. There were 16 consultants to consult with and all wanted to work differently. The arrangement agreed was that a junior doctor would be on call for the CRT and the CRT would be able to book an appointment for the service user to see a consultant within seven days. Over a period of several months it became apparent this system was

not working to anyone's advantage. Eventually the CRTs managed to persuade the consultants the benefits of how they preferred to work.

Another team tackled changes in function by giving staff specific responsibilities. For example, one group of staff looked into risk assessment and how this could be incorporated within the team's practice. This team was fortunate in having access to a spare project manager within the Trust to assist with managing changes, particularly changes at an operational level.

For teams experiencing rapid changes, trying to introduce a system to help manage these often proved impossible. One team lead fed-back to the CRT decisions imposed by senior management. There was some attempt to manage the changes as a team and introduce them incrementally. However, these incremental changes were soon abandoned because of pressure to meet targets. It was this type of pressure that made it difficult for team leads to create a good quality service.

One team lead stressed that there are so many changes that come from government policy. She argued that *'many of them are not relevant to us'*. For example, the provision of a 24-hour CRT service is not really needed in their area. She felt their role was simply to conform to this.

### **Impact of funding constraints on changes**

Almost all the teams indicated that at some stage they had struggled with the lack of adequate funding, particularly when employing social workers, occupational therapists, and psychologists. However, team leads reported having been very creative in using the resources available to them and tried to make the best of their situation. Team leaders were also aware of the effect of continuous changes imposed by the senior management and the barriers created by funding shortfalls. As one team lead expressed:

*'We had financial constraints. The allocated budget was cut by 32%. This made it difficult to get the operational set up and getting the proper skill mix of staff. Gate-keeping/community/out reach everything had changes. There were problems with the one off assessment & home treatment. I had to be very creative constantly.'*

A number of CRTs struggle to comply with the MHPIG and ensure the team had the right skill mix to make up a multidisciplinary team.

A few team leaders described how their team had either merged to become a much bigger team or had split into two when a team had become too unmanageable. Financial pressures in particular determined mergers of CRTs. Decisions to make these changes were usually made by the Trust's steering group. Merging or splitting teams often created logistical problems, especially where accommodation and adequate office space was concerned.

Most team leaders interviewed were very constructive in their approaches and dealt well with the constraints imposed on them. Accordingly, they tried to do the best they could, and encouraged their team to understand that some

actions have to be taken over which they have no control. One of the aspects that helped the team to do this was the vision and passion that the leader instilled in the team, and the satisfaction the team received in helping service users.

### **Change involving external agents**

Almost all teams had difficulty dealing with external agencies such as CMHTs, GPs, A&E and other services, principally when the CRT was being set up. However, all team leads recognised that, in order for their service to be successful, cooperation from external services was vital. External agencies viewed the new CRTs initially as a threat. As one team leader explained, *'the problem with CRTs is that they have to work across boundaries... The best way is to try and remove these boundaries'*. He added, *'CRTs can treat people quickly but they don't always have the back up of other agencies (e.g. the CMHT). They can just turn around and say they are full and that they can't take on any more clients'*.

This meant that the crisis resolution team had to sell their services and explain their role to external agencies, and to find a way to work in partnership. CRTs had to work especially hard with GPs to explain the nature and value of the CRT's role. The majority of team leads mentioned that GPs did not understand what their service offered, even after communicating and explaining to them in detail about what they do. GPs were described as the CRTs *'biggest external critics'* and often reluctant to cooperate or be involved. One team received approximately 10-15% of their referrals from GPs.

One team lead explained how they overcame barriers with GPs. First they decided to be more sympathetic with GPs and to be understanding about their stressful situation – demanding surgeries, etc. The team then began communicating with the GPs on a regular basis to keep them informed of what was happening with their patients. GPs gradually became more confident of the service the CRT provided and relationships with them improved.

Another major challenge was working with CMHTs. All the teams reported having conflicts with neighbouring CMHTs. CMHTs were used to referring directly to the inpatient ward. There were conflicts with CMHTs around point of entry as at the beginning there were no criteria for admission via CRTs. Other conflicts with CMHTs revolved around disputes about caseloads. With time many conflicts would dissolve and a mutual understanding between the two agencies reached, but not without the huge efforts made by the CRT to overcome these difficulties. These efforts included regular contact with the CMHT and by conducting joint assessments with CMHT staff.

Another source of tension with the CMHTs happened with the recruitment of staff to CRTs who moved away from the CMHTs. For a while this left the CMHTs with fewer staff and higher caseloads. Another team lead stepped outside their CRT's remit to help the local CMHT in an effort to improve relationships between them. This flexibility worked during the initial set up of the team, but once relations were better the CRT redefined their parameters and returned to its usual working practices.

Despite initial difficulties with the CMHTs many team leaders described improved relations over time. Some challenges have still persisted, particularly around referrals from CMHTs. One team lead mentioned how their local CMHT will occasionally refer a service user to them without having performed a proper assessment of whether the person was in crisis or not. This same team lead felt that the CMHT's method of risk assessment was inadequate. To remedy these issues the CRT has carried out road shows to demonstrate the importance of getting this right and putting the client first. One team lead encouraged staff from the CRT to go on secondment to the CMHTs to gain a better understanding of how they worked and *vice versa*. Working in close proximity to the CMHTs was said to help create good relationships.

For three teams the most problematic of all relationships with external agencies was with the local A&E department. With the increasing demands experienced by this CRT the level of service they could provide for the A&E department reduced. The main difficulty concerned the CRT not meeting the 4-hour waiting time target A&E departments are set. Again regular meetings with A&E staff and managers within the hospital were arranged in order to resolve these tensions. Another CRT produced a triage tool that provides A&E staff with an indication of who should be referred to them. The team lead for one CRT devised a flow chart to help guide A&E lead clients to the right place if followed correctly. Another problem in this relationship is that A&E departments are very medically led and find it difficult to understand that CRTs are not governed by medical staff.

One of the recurring comments from the team leaders about the external services is that the CRT teams operate very much as a multidisciplinary unit, and that they function successfully through joint working, with each team member offering her/his specialist professional input. Such working creates a supportive environment, and is in contrast to other agencies, which do not have such a culture, where individuals working independently on their particular caseload.

### **Models used when implementing changes**

Of the team leads interviewed for this part of the study 34.6% had used one or more of 12 models to implement changes. The most commonly used models were Five Whys (17.3%) – addresses single-problem events through a series of 5 questions – and Process Modelling (17.3%) – a process used to obtain clarification of different views and expectations. The remaining teams leads, however, were unfamiliar with many, if not all, of the 12 models listed in the Analysing Change questionnaire.

A few team leads had undertaken management courses at MSc level. These particular team leads recognised all models for implementing changes listed in the Analysing Change questionnaire. When asked which models they applied, each of these team leads mentioned that they had not subscribed to any particular one, but had perhaps used elements of all of them in practice. One team lead considered that none of these models suited his approach. Instead

he adopted a solution focused drive in which he consults with staff, through an 'away day' every 3 months, examining the strengths of the team and how these can be maximised.

A pragmatic approach to managing changes was the preferred option for the majority of team leads. If a model for implementing change was applied it was generally done so in a very loose way. Solution-focused models were found to be useful as they lent themselves to consultation with staff and reaching a shared vision in terms of the direction of the team. One team lead utilised an action research approach to introducing incremental changes in the way the CRT operated.

One team lead was clear about his approach. He considered it important to keep people fully informed, to gauge their opinions and get them involved even if senior management had imposed decisions upon them. Another example of an action research type approach was to ask the team '*how do we want to do things?*' The team then worked out a plan for themselves and if it does not work they tried something else.

### **Techniques for implementing changes**

Techniques for implementing changes were more popular than the models. Forty-eight percent of team leads had reported using one of the 12 techniques listed in the questionnaire. SWOT analysis – analysis of strengths, weaknesses, opportunities and threats providing the stimulus for change – was used by 42.3% of team leads that completed a change management interview. Force field analysis was the secondly most commonly used technique (25%). This technique identifies the driving forces that push forward the desired changes and opposes those that inhibit them. Commitment, enrolment and compliance – when change is imposed externally it is unlikely to succeed unless some of those involved favour it and identifies the degree of commitment, enrolment and compliance within the team – was the third most commonly used technique (19.2%).

As with models for implementing change the majority of team leaders described generally not using a particular technique, but instead using practical approaches to identify and evaluate better ways of doing things. One particular team lead believed that all team members led changes within their team. Another felt it crucial to maintain personal contact and develop good personal relationships when managing change. Encouraging autonomy (with support) and being accountable to all team members was described as important for one team lead. For another keeping staff satisfied was important, but at the same time knowing when to say no.

### **Change management**

As far as the management of change was concerned, it proved impossible to test the hypotheses since in all cases the team lead's responses to the Analysis of Change interview suggested that they all adopted a transformational (i.e., continuous, iterative), rather than a 'transactional' (incremental; or 'unfreeze-move-freeze') approach to managing change.



Formally, then, the data collected did not provide evidence in support of or against Hypothesis 7.

The next section goes on to report the findings of eight in-depth Case Studies that were conducted as part of the project.

## SECTION 6 – RESULTS 2: CASE STUDIES

At the stage when selection of low *versus* high admissions teams had to be made, admissions data were available for only 19 teams. The selection, therefore, refers to low, not lowest admissions teams, and high, not highest admissions teams.

### Case Study L1: Low admissions team

Ten members of staff completed the LCCI at time one. When the questionnaires were administered there were 11 members of staff in the team, so the response rate for the team is 91%. Ten members of the team were interviewed as part of the case study.

#### **Context**

##### *Background*

L1 is a CRT based in a socially deprived Northern town. The MINI score for the area is 1.38, indicating substantially higher than average mental health needs in the area. There are sixteen full-time staff and two part-time staff in the team, of which there are: two social workers, one occupational therapist, two support workers, one full-time psychiatrist, two administrative staff and ten mental health nurses. The team was formed in June 2003, prior to which was a team of two Registered Mental Health Nurses (RMNs) and three support workers providing intensive home treatment 9am-5pm, seven days a week.

The team serves a population of approximately 100,000. The average case load is 17 service-users at any one time and there is no declared limit on how many service users the team can see. There are no strict criteria on how long service users are seen for; the norm is approximately six weeks, but this can be longer if therapies are in progress. The average proportion of service users with psychosis is 30 percent.

The team is fully gate-keeping and provides 24 hour care, 365 days of the year. The majority of staff work 12 hour shifts (9am-9pm) and the period from 9pm-9am is covered through their on-call system.

Since the team was set-up there has been one change in team leader, with the original team lead taking a more senior position. A practitioner, who was already working within the team, took over the role of team lead. This person was one of the members of the original staff that came from the home treatment team.

#### **Setting up the team**

##### *Initiation of the team*

The initiation of the CRT came from the two RMNs working in the existing home treatment team. The MHPIG had just been published and they realised that with their existing resources they were unable to function as a CRT. As the home treatment team only had two RMNs and three support workers,

there was a severe limit on their caseload capacity, especially with regards to crisis referrals, and the out of hours cover they could provide in the community.

The RMNs working in the team undertook some research, with the help of a researcher, to systematically ascertain what was required for them to function as a CRT. Once this research was completed, they presented the results to the PCT who then agreed the funding for the CRT. The funding was agreed incrementally, so the service was phased-in. Although the team became operational in 2003 it did not become fully compliant with the MHPIG until 2005.

The fact that the CRT was initiated by the existing home treatment staff shows an earlier proactive and committed approach to service development from the mental health professionals involved. This is different from some other CRTs, where the initiative to work as a CRT, especially in relation to compliance with the PIG, came from the PCT.

#### *Planning the service*

L1 was fortunate because the team lead was appointed one year prior to the commencement of the service, so had a substantial period of time solely dedicated towards service development.

#### *Working with stakeholders to develop the service*

The team is in a complicated position as it services an area that has three different provider trusts, with each trust having a different culture, especially with regards to how prepared they were to relinquish the medically led approach to service delivery. A steering group was set up containing senior people from all three trusts along with service users and carers, the purpose of which was to discuss and plan how the service was going to operate.

Along with the Steering Group, a Working Group was also initiated. This group involved members from all the mental health services in the area. Again, this group was for discussing how the team was going to operate.

To inform GPs about the new service, the team lead visited the practices in the area.

#### *Initial staffing of the team*

The team lead was externally recruited for the position. He inherited the five existing staff from the home treatment team then externally recruited the remainder of the team.

The team lead had a very clear idea of what he wanted from the people he externally recruited. He wanted staff that were committed to the vision and values of crisis resolution and home treatment. He also wanted staff with considerable experience so that they would have the skills and experience necessary to take positive risks and manage people's treatment at home.

There were difficulties associated with inheriting staff. The first difficulty was that one of the RMNs from the existing home treatment team applied for the position of team lead and failed to get the position. The appointed team lead addressed this by talking to the person about this when he first started, expressing that he hoped it would not get in the way of their working relationship.

The second difficulty was that the existing home treatment team had a fixed way of doing things, which caused tension within the team. Of the original five existing team members, there is now only one remaining. The person who applied for the team lead position left for a promotion elsewhere, and the other staff left because of the change in shift patterns that accompanied the new CRT. The person remaining in the team was promoted to team lead a year ago.

None of the staff externally recruited have left the team.

This highlights the difficulties associated with inheriting staff. If people do not specifically apply for/ or are not specifically recruited for a particular position then it may be difficult to match the motivation, interests, skills and experience to the job that they find themselves doing.

#### *Initial team development*

The team was in the fortunate position of having a ten day uninterrupted induction period. Five of these days were spent on the crisis model with the Sainsbury Centre for Mental Health. The remainder of the time was spent developing an operational policy, developing a clear understanding of roles and functions, sharing concerns, and giving people the opportunity to ask questions. The team lead believed it was very important to consult and communicate with the team members at this time so that people had a sense of shared ownership.

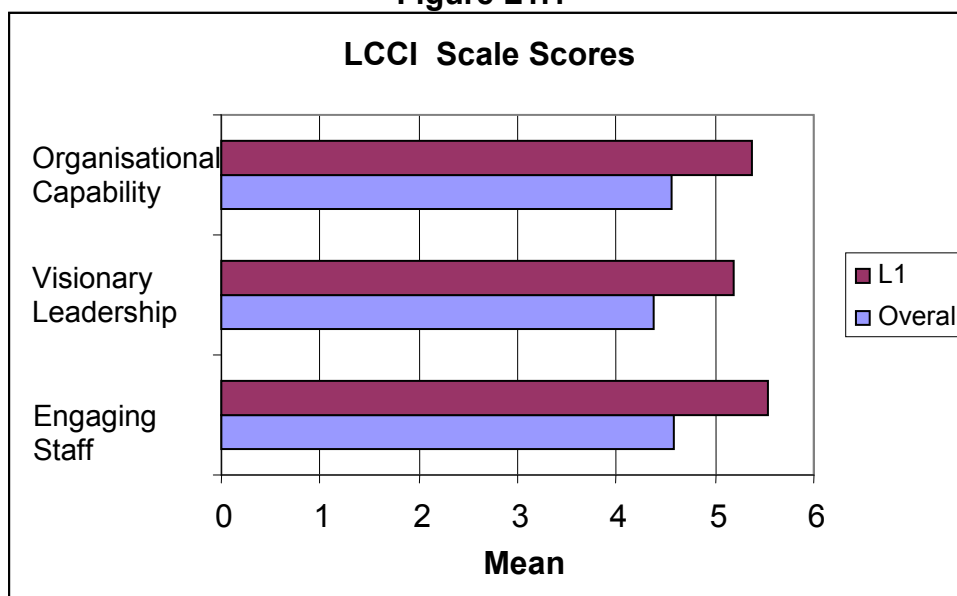
Most importantly, the team lead used this time to develop the team vision. He felt that it was very important to have a clear vision from the outset so that people would have a clear sense of what they were working towards.

### **The Team**

#### *LCCI Scales*

The results for the three main LCCI scales are presented graphically in Figure L1.1. The detailed results are tabled in Table L1.1. It can be seen from these that L1 performs very positively on the LCCI. The means for the LCCI scales are all above 5, which is indicative of very effective leadership within the team. At the time the team completed the questionnaire, they felt their leader was engaging (mean 5.53, SD 0.36), was able to provide a strong vision for the team (mean 5.18, SD 0.63), and was also capable of running the organisation (mean 5.36, SD 0.41). It can be seen from the large effect size differences in Table L1.1 that L1 scored substantially more positively than the overall sample.

**Figure L1.1**



**Table L1.1**

LCCI Scales							
	Overall			L1			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	10	5.53	0.36	<b>1.10</b>
Scale 2 - Visionary Leadership	727	4.38	0.89	10	5.18	0.63	<b>0.91</b>
Scale 3 - Organisational Capability	728	4.56	0.79	10	5.36	0.41	<b>1.01</b>

*Team Vision*

It is evident from what has been discussed previously that the team lead felt it was very important that there was a clear vision for the team, and he recruited staff on the basis of their vision and then went on to develop this collectively during the induction period.

From the interviews this joint vision was very apparent. There is a very clear aim within the team of providing an alternative to hospital admission through caring for people in their own homes. The approach is user and carer centred, and is holistic in nature, taking in to account the social, relationship and cultural influences on a person’s health, not just the medical factors.

There is an overwhelming sense of commitment to the team’s vision from all members of staff and a tremendous sense of motivation to achieve it. This was very apparent in the way in which some of the interviewees talked about the care they delivered.

The philosophy, vision, aims and goals of the team are continually kept alive through regular team communication forums, such as away-days, daily handovers, and weekly team meetings. The care delivered and service development is constantly embedded in the team philosophy.

## Composition of the team

### *Multidisciplinary*

The team is truly multidisciplinary, containing: nurses, social workers, support workers, an occupational therapist, and one full-time dedicated psychiatrist. The nurses, OT and social workers have core roles and have the same job title, but there are disciplinary differences in the way they carry-out their roles. The team lead found that managing a multidisciplinary team was quite challenging; he encouraged open discussion of this with the team and made sure that assumptions were not made about other people's roles.

There is a clear sense from the interviews that people regard the multidisciplinary nature of the team as a real advantage for service delivery. The disciplines complement one another, enabling a truly holistic approach to home based care. There is the belief that if someone is to be cared for in their social environment, it is necessary that there are staff within the team, such as social workers and occupational therapists, that have an in-depth understanding of the social problems that service users experience.

### *Full-time dedicated psychiatrist*

The team has a dedicated full-time psychiatrist who works 9am-5pm, Monday to Friday. The psychiatrist is fully committed to the crisis model and recognises that he has different skills to the rest of the team and that these are complementary, rather than superior.

The presence of a psychiatrist is felt to be advantageous in helping people to be cared for at home. It means that if there are medical concerns, such as medication issues, then the service user can be seen without delay.

### *Team expertise and experience*

It is clear from what has been discussed that the team is multidisciplinary in nature so, therefore, has a broad spectrum of expertise within it. The staff are also very experienced practitioners, with their level of experience being one of the key factors for their recruitment into the team. This experience is one of the factors that contribute to successful risk management.

The quality of the staff in the team is expressed in the following comment by the team psychiatrist: *"I mean it is a very, very good team. I'm very impressed with the quality and expertise of my colleagues; it's probably the most competent group of people I've ever had the pleasure to work with"*.

The experienced nature of the team suggested that the staff are mature, both in a chronological and attitudinal sense. Not only do they have considerable experience of working with people experiencing mental health problems, they also have considerable life experience, which, according to one of the interviewees, makes them able to empathise more with service users and also makes service users more likely to trust them.

### *Team structure*

The team structure is reasonably 'flat' with regards to hierarchy. The team lead is a higher grade than other staff, but since Agenda for Change, the majority of staff fall into the same Band: Band 6. This levelling of hierarchy was felt to be an advantage, especially to those staff who were previously 'F' grades, when others were 'G' grades (more senior). One of the interviewees described the team as 'egoless' because of its flat hierarchy.

This relatively flat hierarchy means that the qualified staff function as autonomous practitioners. They work quite independently but with support from other team members. They are aware that the team lead is 'the boss', but this is in a supportive rather than autocratic sense.

The support workers are on a substantially lower grade than the other team members. Up until recently their role has been to support more senior staff. However, the team is currently trying to develop the role of the support workers into support time recovery workers, which is a more autonomous and therapeutic role.

The psychiatrist does not belong to the same professional hierarchical structure as the rest of the team. He belongs to the medical structure within the trust, so is not directly governed by the team lead. The psychiatrist considers himself to be the clinical lead for the team, particularly with regard to medical issues. This is certainly not him inflating his position in the team, as he feels all of the practitioners in the team take a leadership role in the areas where they have the expertise to do so.

The original team lead made an interesting comment about hierarchy. He said that originally he used to ignore hierarchical differences but he now acknowledges them and works within them. This was in particular reference to using a facilitator to facilitate away days, as he is aware of the effect his presence can have on the team members. This comment seems to demonstrate quite strongly the self awareness the original team lead had, and how he reflected and acted on these reflections in his leadership role.

### *Relationships within the team*

It is very clear from the interviews that relationships within the team are very positive. People feel very much supported by their fellow team members; the following comment by one of the interviewees is just one example of this: "*People will go the extra mile and stick their necks out to help one another*".

The relationships also seem to be very open within the team. A lot of the interviewees commented on how it was possible to express concerns, anger, and alternative opinions openly without there being any repercussions for the staff in the team. This element of the team was felt to be advantageous for those working within it, especially considering the stressful nature of crisis work.

This lack of fear of conflict within the team was something the original team lead wanted to promote from the outset. He firmly believes that people should be able to voice their opinion when they feel things are wrong.

The supportive and open relationships in the team are very important from a positive risk taking perspective. The team discuss collectively particular cases and jointly decide on a plan of care. The interviewees felt very strongly that the supportive environment helped them in managing high-risk situations.

#### *Team development*

As previously mentioned, during the initial induction period the team spent ten days together developing a model of how they were going to work. Since this time the team have regular half-day facilitated away days to help develop team working.

Apart from away-days there are other forums where the team meet and discuss. Every day there are detailed clinical handovers, where each service user's care is discussed. There are also weekly team meetings where operational issues are discussed and where there is an opportunity for group clinical supervision. Time for weekly meetings is generally protected so that as many staff as possible can attend.

Both the daily handovers and the weekly team meeting were considered to be very valuable for all of those interviewed; staff will sometimes come in on their days-off to attend the meetings. They provide a time to discuss concerns, share ideas, problem solve, and collaborate to develop a plan, whether it be about a clinical situation or about an operational policy. It gives the team members a sense of shared decision-making, which, again, from a **risk** management/developmental perspective is very important, especially when on a shift basis practitioners work relatively autonomously.

#### *Continuing professional development*

There definitely appears to be a culture of continual professional development in the team, both on a team level and an individual level. The weekly team meetings are sometimes used for educational purposes, where staff within the team will present, or talk about a particular aspect of care that they have expertise in. For example, the psychiatrist will occasionally educate staff on the medical aspects of a particular mental health problem.

At an individual level, people have a professional development plan, which they are required and encouraged to complete. They will discuss this with the team lead at individual management supervision every six months.

The management supervision is used to discuss individual professional development and also any problems a team member may be having at work. If problems are identified the team lead will offer support on a regular basis in the form of close supervision. This time is also used by the team lead to address any problems evident in a team member's performance so that a plan for improvement can be developed.



## **Relationships with external agencies**

### *Relationship with the Primary Care Trust*

The original team lead, the current team lead and the psychiatrist all said how good the relationship between the CRT and the PCT was. The PCT sees mental health as a priority, which has made it easier for them to develop as a service compared to teams with an unsupportive PCT. The team's relationship with the PCT is summarised by a comment made by one of the interviewees:

*“Our job has been made so much easier because we have a very supportive PCT. The PCT is absolutely brilliant – mental health is right at the top of their agenda. They're right behind us; well actually they're ahead of us in some respects”.*

The CRT works with the PCT to develop protocols for service delivery. This is helpful when the CRT is experiencing difficulties in obtaining cooperation from external agencies because, if necessary, they can say that it is trust protocol and needs to be adhered to.

The relationship with the PCT is set to change, as three PCTs are merging to become one. It is anticipated that the addition of the new trusts is likely to cause problems with the gate-keeping role of the CRT, as the culture of one of the trusts in particular is *“autocratic and medically led”*.

### *Relationships with other external agencies*

When CRTs were first introduced they represented a new way of working that resulted in significant changes in the way mental health services were delivered. The CRTs became the central point for mental health crisis which means that they have to work with multiple agencies, some of which are mental health services, such as CMHTs and specialist mental health teams, and some which are not specifically related to mental health, such as GPs, A&E, and police stations.

## **Difficulties with multi-agency working**

### *Dominance of the medical model culture*

It has been very difficult for some mental health workers to accept that medical staff are no longer the ones that have the responsibility for making the decisions on whether a person should be admitted to hospital or treated at home.

### *Underestimating the level of risk the team can manage*

Mental health workers outside of the crisis team seem to find it difficult to understand the level of risk that CRTs can manage at home. When service users mention suicide, the automatic reaction is for other services to think hospital admission and feel very uncomfortable if this is not the case. This is linked to the dominance of the medical model culture.

### *Perceptions of the crisis team as a ‘dumping ground’*

There is a feeling amongst the crisis team that they are perceived as a dumping ground by other services in the area. They feel they get asked to fill the holes that exist in mental health service provision in the area. Examples of this include getting asked to take on deliberate self-harm work that really is not within the remit of crisis work, and being asked to do out-of-hours home visits for CHMTs.

#### *Lack of clarity of roles and responsibilities of the crisis team*

External agencies seem to be confused about what the CRT's remit and boundaries are. This is partly due to constantly changing service developments beyond the team's control and partly due to the team's flexible approach in working with external agencies. An example of changes beyond the team's control is that the trust has recently appointed the CMHTs as the single point of access for all mental health referrals. According to the interviewees, the decision to make the CMHTs the single point of access instead of the CRT does not make intuitive sense, so there has been a lot of confusion and frustration from other agencies because they are not clear who to make referrals to.

With regards to the team's flexible approach, the team have tried, where possible, to accommodate the needs of external agencies, even if it is beyond their remit. For example, they will go and do a home visit out-of-hours for a CMHT if they have the time. However, this flexible approach can lead to inconsistency in what the team delivers and, ultimately, ambiguity over their roles. For the external agencies working with the team this can be frustrating.

#### *Inappropriate referrals to the team*

This is largely a problem with the agencies that are not mental health specific, such as GPs and A&E. To some extent this is due to a lack of awareness of, or priority attached to, mental health issues. However, primarily it seems that these agencies are working within the constraints of their own services, and referral to the crisis team seems like a viable option to solve their own service problems. For example, a GP may not have adequate time to assess a person with a mental health problem satisfactorily; consequently their immediate reaction may be to refer to the CRT. Similarly, A&E staff have strict four hour waiting times to adhere to; to try to get someone out of A&E they may refer to the CRT inappropriately, for example, when the person referred is intoxicated.

### **Approach to building good relationships with external agencies**

It is clear from the interviews that from the outset the team has worked hard at developing positive relationships with external agencies, and that they continue to do so. They do this through:

#### *Being sensitive*

It is clear from the interviews that the team is sensitive to the circumstances of the external agencies. So, although there may be frustrations, for example when they get inappropriate referrals, there is an understanding of the pressures that the agencies are under.

### *Being respectful*

Respect for the external agencies' skills and knowledge is also something the team value. The following quote from the original team lead illustrates this: "*I feel it's important to respect the skills and knowledge outside the team. I discuss decisions, work with people and listen and respect them*".

### *Consultation and communication regarding service developments*

As mentioned previously, when the original team lead was setting up the team he was aware of the need to develop good working relationships with the multiple agencies involved in crisis work. When he set up the team he ensured that representatives from all the relevant teams were part of a working group so that they were consulted and involved in the service development.

There are forums in the PCT where representatives from the mental health services meet to discuss service provision; members of the CRT do attend these.

### *Phasing the service in incrementally*

The team decided to gradually implement the service, engaging initially with professionals that were more amenable to the intensive home treatment approach and then using the successes there to illustrate to more sceptical agencies what the team was capable of.

### *Flexible approach*

Because the team are very user-centred and because they are sensitive to the needs of external agencies, they adopt a very flexible approach to the service they deliver. They try to accommodate requests that are made for their services, even if it is not within their remit.

As discussed above, this flexible approach can cause problems for the team in-terms of them feeling a bit like a 'dumping ground', and also with regards to the inconsistency in service provision when the team do not have the scope to be flexible.

### *Education*

The team educates other agencies on the role of the CRT, the service they provide, and the level of risk they can manage at home. They do this through formal group presentations, and through more informal individual education. They encourage professionals from other agencies to come and work with the team for a day or two so that they can understand what they do. Members of the CRT will also spend time working in other teams so that they can obtain an understanding of how they work.

### *Being autocratic if necessary*

Ultimately, if all else fails and an external agency refuses to cooperate, the team will refer to protocol and will use their positive relationship with the PCT to enforce this protocol.

### *Being Pragmatic*

The team lead and the rest of the team appear to be quite pragmatic in recognising that you can not please all people at all times. Disagreements on a particular issue fit into the broader picture, which on the whole is a positive relationship that evolves over time.

### **Focus on leadership**

Evidence of leadership is permeated throughout what has already been discussed in this case study. It is useful at this point to bring together the key elements of leadership that have emerged from the research in the team.

### *Respect from the team*

All the interviewees spoke very highly of the past and present team leaders. One of the interviewees said of the original team lead: *“We had [original team lead] at first and I could never, ever fault him at anything – he’s just the perfect manager”*. There was a genuine sense of respect for the team leaders.

### *Inspiring and visionary*

It is evident from what has been discussed that a clear vision was very important to the original team lead. All the interviewees share the same strong vision of what the team is and the service it should provide, and are motivated and committed to achieving this.

### *Team focused*

The team leads, past and present, have been very team focused. Team development has been a priority for them and there are multiple forums available for team development to occur (e.g., away-days, weekly team meetings, daily clinical caseload discussions). There is a strong sense that the team works as a team. One of the interviewees summarised this nicely by saying: *“we aren’t a group of individuals; we are a collective group working together”*.

The team leads have also had the best interests of the team at heart. They discuss issues that may affect the team with the team, for example PCT initiatives that result in changes in service, and they will collectively formulate a response which the team lead will present and support at the relevant meetings.

### *Supportive*

Team lead support was one of the clear themes that emerged from the interviews. The team leads have been supportive of the team (as discussed above) and of the individuals within the team. Support is offered on professional and personal issues, with team members knowing that they can trust the team lead to treat them with respect and integrity. The support may lead to action from the team lead on behalf of the team member. This support is a real source of strength for the team members, especially when they often are working in intense situations.

### *Approachable*

All the interviewees felt the team lead was approachable and that this approachability was one of the key components of leadership effectiveness. This is strongly linked to the team lead being supportive.

### *Presence*

It was important for the interviewees that the team lead is a visible presence, rather than locked away in another office. The team lead spends the majority of the time in the team office, being available to provide support and advice.

### *Collaborative*

As the CRT has to work with multiple agencies it is essential that the team collaborates effectively with these agencies. It is clear that collaborative working has been a priority for the team leads; they respect the other agencies that they work with and, where possible, try to accommodate their needs.

An important aspect of this theme is that whilst the team lead is supportive of the team members, if there had been a problem with a team member and an external agency, the team lead would listen to both sides of the story and not automatically jump to the defence of the team member.

### *Democratic*

The team leads have definitely been democratic in their management of the team. All team members are given the opportunity to put their point of view across and they know that this will be considered. There are multiple forums for the team to express their views, and there was an active effort on behalf of the original team lead to ensure that people felt able to do this openly. Because the team is so democratic, the team lead's role is often one of facilitation and coordination.

### *Pragmatic*

Both the team leads were aware that sometimes there will be external initiatives that are not in the best interests of the team but that the team will have little control over. For example, the team recently have had to undertake deliberate self-harm work that is beyond their remit and adds to their workload. Despite their best efforts to try and prevent this initiative, ultimately the decision could not be changed. With regards to this particular initiative, the team lead accepted that there was nothing that could be changed and used a problem solving approach in addressing the situation. So, for example, saying to the team: *'this is what has happened, we can't change it, so how will we work with it?'.* This kind of approach is helpful because it diffuses what can often be a very emotional and tense situation.

### *Taking control in a sensitive manner*

One of the key themes to emerge for the interviews has been the ability of the team leaders to be able to take control of a situation when an outcome is proving difficult to reach. If there are differences within the team then the team leaders will ultimately make a decision on what the outcome will be. When this

situation arises, the team lead will be understanding of everyone's opinions and will give a rationale for why a particular course of action has been chosen.

#### *Integrated approach to leadership*

There is definitely a sense that whilst the team lead is ultimately "the boss", all members of the team are leaders to a certain extent. Because the practitioners in the team are autonomous professionals, with expertise in different areas, whoever takes leadership on a particular issue will depend on the skills and experience that this person possesses. The multiple forums for team communication give people the opportunity to express their desire to lead on a particular issue, and there is a clear sense that team members are willing to this.

#### *Knowledge and skills to manage and develop the service effectively*

It is clear from the interviews and from what has been discussed already in this case study that both the team leaders have been competent in knowing what is required to manage and develop the service effectively. Ever since the team was in the planning phase of development, the leadership has known what to do to take the service forward. The team leads have been very good at recruiting the right staff, managing the team and individual performance (through group and management supervision), and building relationships with external agencies. As such, there are solid structures in place that enable the team to deliver effective home based, user-centred crisis care.

#### *Clinically skilled*

Although the team leads spent most of the time in the team office, the majority of interviewees felt that it was important for the team lead to have good, up-to-date clinical skills and to be willing to help-out clinically when required. This gives the team lead credibility, it also means that they can 'help-out' if the team is short staffed, and that they can truly identify with what the team members experience on a day-to day basis.

#### *Reflective*

There was a definite sense from the team lead interviews that the leaders have critically evaluated their own performance and, where necessary, taken steps to alter their approach. For example, when the original team lead was talking about his approach to consultation, he felt that he had consulted too much with people and should have been clearer about what was appropriate for consultation and what was not.

### **Outcomes**

#### *Hospital Admissions Data*

The team were chosen as a case study team because of their low hospital admission rates (outlined in Table L1.2). Further analysis of these data show that the average percentage of people referred to the team that are admitted to hospital is 7%, and the average number of people assessed by the team that are admitted to hospital is also 7%.

**Table L1.2**

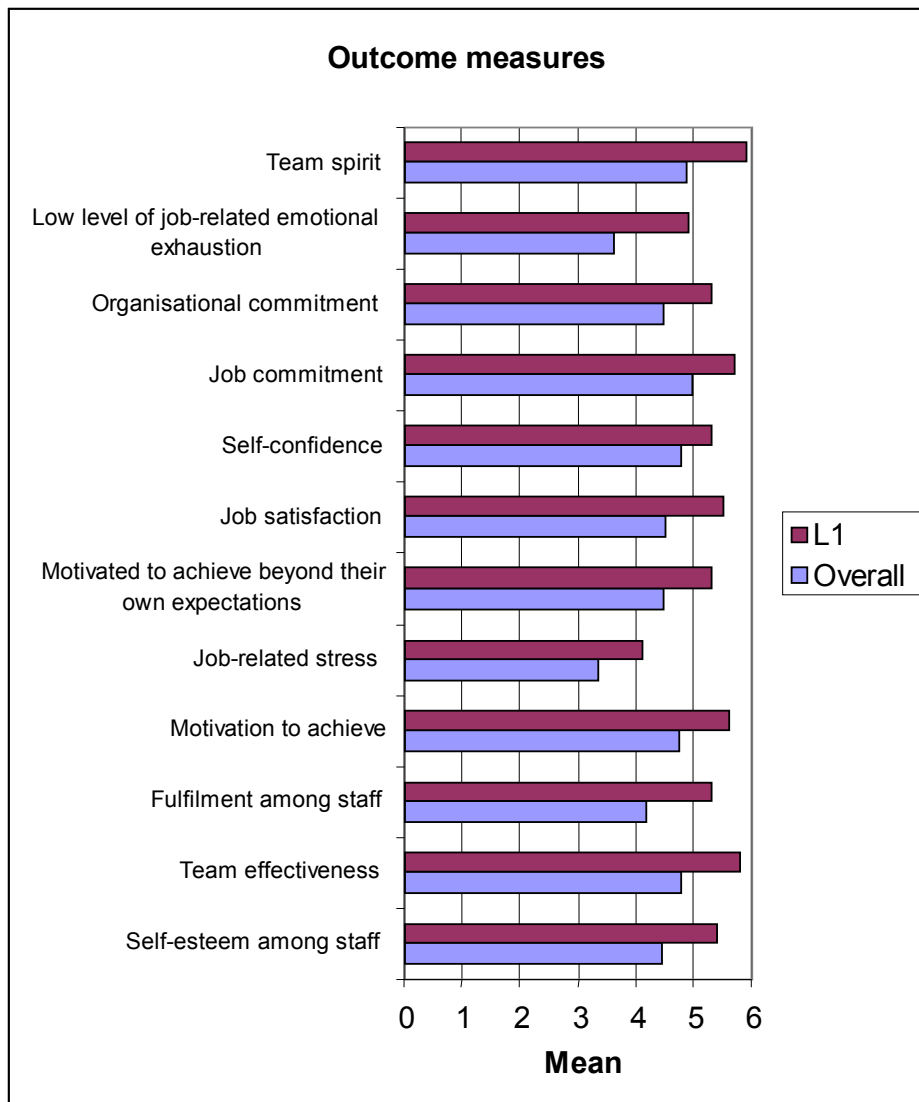
	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Sep-05</b>	43	38	4
<b>Oct-05</b>	41	39	3
<b>Nov-05</b>	44	42	2
<b>Dec-05</b>	25	25	4
<b>Jan-06</b>	57	53	3
<b>Feb-06</b>	55	53	4
<b>Mar-06</b>	45	43	6
<b>Apr-06</b>	38	35	2
<b>May-06</b>	54	51	1
<b>Jun-06</b>	62	61	3
<b>Jul-06</b>	59	59	2
<b>Aug-06</b>	51	51	1

*LCCI Outcome measures*

The LCCI outcome measures are presented graphically in Figure L1.2, with the more detailed results presented in Table L1.3. It can be seen from these that a positive picture has emerged. It is clear that the team is a confident team that works well together. It is also evident that there is a high level of commitment, satisfaction and motivation amongst the team members. The only outcome measures where the mean falls below 5 are for job related stress (mean 4.10, SD 0.99) and job related emotional exhaustion (mean 4.90, SD 0.74).

It is particularly evident how positive L1's LCCI scores were when they are compared to the overall sample results. The effect size differences for most of the outcomes were either medium or large.

**Figure L1.2**



**Table L1.3**

LCCI Outcome Measures							
	Overall			L1 team			Effect size differences
	N	M	SD	N	M	SD	
Self-esteem among staff	721	4.46	1.25	10	5.40	0.70	<b>0.75</b>
Team effectiveness	725	4.78	1.12	10	5.80	0.42	<b>0.92</b>
Fulfilment among staff	717	4.17	1.26	10	5.30	0.48	<b>0.90</b>
Motivation to achieve	720	4.73	1.03	10	5.60	0.52	<b>0.84</b>
Job-related stress	712	3.35	1.47	10	4.10	0.99	<b>0.51</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	10	5.30	0.67	<b>0.74</b>
Job satisfaction	712	4.51	1.23	10	5.50	0.53	<b>0.81</b>
Self-confidence	714	4.78	1.02	10	5.30	0.67	<b>0.51</b>
Job commitment	718	4.98	0.93	10	5.70	0.48	<b>0.77</b>
Organisational commitment	719	4.46	1.07	10	5.30	0.82	<b>0.79</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	10	4.90	0.74	<b>0.90</b>
Team spirit	720	4.89	1.20	10	5.90	0.32	<b>0.84</b>



## **Conclusion**

It is very clear from what has been discussed that L1 are an extremely motivated and committed team. There is a strong sense of purpose within the team to achieve the vision of user-centred, holistic crisis care in the community.

The team appears to have been led very effectively by the two team leads that it has had. These leads have been visionary and committed. They have been extremely supportive of the team and the individuals within it. The leadership had been generally facilitative through providing the support and guidance that enables team members to lead and practice in the way they desire. The team is also very democratic, with a high level of consultation and shared decision-making.

The team is hindered by continual changes to the service that are beyond their control; this causes confusion and results in difficulties with their relationships with external agencies. However, the team is helped by the positive relationship they have with the PCT, which is committed to the principles of CRTs.

## Case Study L2: Low admissions team

Ten out of 14 members of staff completed the LCCI at time one, making the response rate for the team 71%. Seven members of the team were interviewed.

### **Context**

#### *Background*

L2 is a CRT based in a socially deprived Northern city. The MINI score for the area is 1.35, illustrating substantially higher than average mental health needs in the area. There are fourteen full-time staff and two part-time staff in the team, of which there are: two social workers, four support workers, one full-time and one part-time administrator, and seven full-time and one part time mental health nurses. The team had been in existence since November 2003.

The team serves a population of approximately 150,000. The average caseload is 22 service users at any one time and there is no declared limit on how many service users the team can see. There are no strict criteria on how long service users are seen for. The average proportion of service users with psychosis is ten percent.

The team is partially gate-keeping and provides 24 hour care, 365 days of the year. There are a variety of shift patterns, with the period from midnight to 9am being covered by on-call.

Since the team has been in existence there has been no change in team lead.

### **Setting up the team**

#### *Initiation of the team*

Prior to the introduction of the crisis team there was no community based crisis resolution work in the district. People working in mental health in the area were acutely aware of the need to have a better response to crisis work, as previously any response to urgent work was to the detriment of the planned work of the CMHTs.

At the time the MHPIG was published, the team lead and his colleagues were in the process of trying to establish some form of crisis care in the area. It is evident from this that there was a genuine commitment to crisis care and the motivation to make this happen prior to the formation of the CRT on behalf of the team lead.

#### *Planning the service*

The team lead had approximately three months to plan the service.

Stakeholder events with users and carers, GPs, the police, and CMHTs were conducted to shape the way in which the service was going to be delivered. The service has largely been developed out of the needs of service users and carers; this has always been a priority for the team leader.

### *Initial staffing of the team*

The team lead was approached by the Trust to project manage the development and running of the CRT because of his clinical and managerial experience. Obviously there was recognition that he would be the best person to undertake these activities.

The team lead was initially offered funding for his position and four RMNs. However, he secured funding for another ASW by arguing that this was required for the team to function adequately. Hence, here there is evidence of the team lead's negotiating capacity.

As the team was being set-up from scratch, the team lead was primarily responsible for recruiting staff. The only constraint, due to funding issues, was that staff had to be appointed from within the Trust. The team lead had a clear idea of what he was looking for in people when he was recruiting for the team. He wanted people with considerable experience so that they would have the skills and knowledge necessary to make decisions about people's care, to take positive risks and to manage people's treatment at home. Because the team lead had worked in the mental health services in the area for several years, he knew all the people that he recruited. The people recruited were senior clinicians in the Trust that had a great deal of experience in acute mental health care.

The team lead did not have total control over recruitment, as he also inherited three support workers from a disbanding community team.

### *Initial team development*

The team had a ten day uninterrupted induction period. Five of these days were spent on the crisis model with the Sainsbury Centre for Mental Health. The remainder of the time was spent developing an operational policy, sharing concerns and giving people the opportunity to ask questions. A particular emphasis was the management of risk. The team lead believed it was very important to reiterate to the qualified practitioners that working in the CRT was not hugely different with regards to risk than their previous roles and that it was just a different focus. As such, he did not need to do formal training with this group of staff. However, he did do formal training with the support workers on risk management during the induction, as they had not experienced crisis work before.

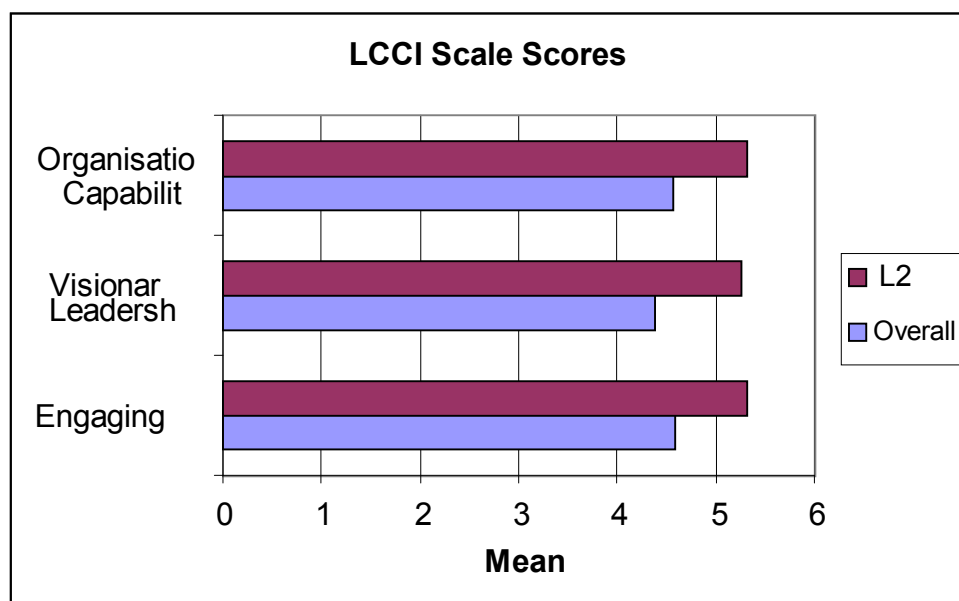
## **The Team**

### *LCCI Scales*

The results for the three main LCCI scales are presented graphically in Figure L2.1. The detailed results are presented in Table L2.1. It can be seen from these that L2 performs very positively on the LCCI. The means for the LCCI scales are all above 5, which is indicative of very effective leadership within the team. At the time the team completed the questionnaire, they felt their leader was engaging ( $m=5.31$ ,  $SD 0.47$ ), was able to provide a strong vision for the team ( $m=5.25$ ,  $SD 0.36$ ), and was also capable of running the organisation ( $m=5.31$ ,  $SD 0.49$ ). It can be seen from the large effect size

differences in Table L2.1 that L2 scored substantially more positively than the overall sample.

**Figure L2.1**



**Table L2.1**

LCCI Scales							
	Overall			L2			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	10	5.31	0.47	<b>0.84</b>
Scale 2 - Visionary Leadership	727	4.38	0.89	10	5.25	0.36	<b>0.99</b>
Scale 3 - Organisational Capability	728	4.56	0.79	10	5.31	0.49	<b>0.95</b>

### Team Vision

It is evident that there is a very clear vision of providing good quality care for people in their homes. The approach is user centred, and all operations are framed in terms of what is best for the user and carers. Key elements of the team’s vision are to be holistic in nature; taking into account the social and relationship factors that affect people’s mental health.

Central to the vision is for the team to be flexible with regards to cases that they will accept for treatment so that they can be responsive to the needs of users and carers; this is evident in the following comment made by the team lead: *“Our philosophy is that there is never an inappropriate referral”*.

There is definitely a shared vision amongst the team members; as one of the interviewees said: *“We are all working to the same thing”*. From the interviews it is apparent that the team lead is instrumental in shaping, maintaining and driving forward this shared team vision, as the following comment by one of

the team indicates: “[team lead] is quite clear about what he wants the team to achieve [...]. I think often because we’re so busy you kind of get caught up in things and lose perspective – he’s quite good at maintaining that”.

One aspect of the vision that emerged from L2 is that there is a shared vision not just within the team but also within the locality. When the team lead talked about setting up the team and about its current functioning, he talked about a passion in the local mental health community for providing good quality, user-centred care.

Another interesting aspect of the team lead’s vision is for the mental health care that is delivered in the area to be recognised nationally.

The local vision and the desire for national recognition are demonstrated by the following comment made by the team lead:

*“I want us to be a beacon for mental health services. I think we have a fantastic group of staff in this team, but also the CHMTs have excellent staff, and we’ve never been good at, and I blame the bosses above, is that we’ve never been pushed or promoted nationally so that our work is recognised. I sometimes wonder whether their passion is as strong as mine, and I’m just one of many passionate people in the Trust and the team”.*

This comment is one of many comments that highlight the commitment, motivation and enthusiasm of the team lead. This enthusiasm was also evident in the other team members that were interviewed.

## **Composition of the team**

### *Multidisciplinary*

The team contains nurses, support workers and social workers. There is a clear sense from the interviews that people regard the multidisciplinary nature of the team as a real advantage for service delivery. The disciplines complement one another, enabling a truly holistic approach to home based care.

### *Psychiatric input*

The team has a consultant psychiatrist for two hours a day and a senior house officer for two sessions a week. This level of input is highly satisfactory for the team, especially since at times they have had no dedicated medical support at all. It is not felt that a higher level of consultant input is required since the service is practitioner led; the team will consult the psychiatrist only if they feel it is necessary.

The team has a good relationship with the consultant. The consultant respects the skills and expertise in the team and will not dominate the decision-making with regards to the plan of care. The consultant feels that he benefits from the service the crisis team offers with regards to reduced hospital admissions, and also feels that it is possible to act as a consultant in the team, rather than

having to see all service-users routinely, which is the case in other mental health services.

#### *Team expertise and experience*

As previously discussed, the team consists of nurses, social workers and support workers; as such, the team has expertise in both the medical and social side of care. The staff were recruited to the team for their substantial experience, their capacity to make decisions and their willingness to take responsibility; it is the combination of these factors that contributes to successful risk management.

#### **Team structure**

L2 is relatively non-hierarchical. People respect the team lead for being “*the boss*” and he will use his position as the team lead to take control of a situation. Whilst there are differences in qualifications and experience within the team, the team works as an integrated unit, with all members being respected for their unique contribution. The lack of hierarchy has been a deliberate strategy of the team lead. Since the start he has ensured that everyone shares the same office and sits around the same table within this office.

#### **Relationships within the team**

It is clear from the interviews and observations that relationships in the team are good. The interviewees commented on how well they get on with each other and how supported they felt. The team is made up of “*strong personalities*”, where people are opinionated and not afraid to express their views. This is a positive element of the team because it leads to open and sometimes heated discussion where there is no reprisal, as disagreements and conflict are resolved quickly and transparently.

The team definitely appear to work as an integrated unit. The caseload is considered to be a joint caseload in which everyone contributes. Each person’s care is discussed and planned amongst the team, and staff are given the opportunity to talk about difficulties and raise concerns that they may be experiencing. These supportive and open relationships in the team are very important from a positive risk taking perspective.

Whilst relationships are generally good in the team, the team lead will monitor this and address any problems that he feels are developing.

There is clearly a lot of ‘banter’ that goes on in the office. There is a joint sense of humour that is “*extremely, extremely black*”. The team lead believes that humour is a good way of diffusing the stress of working in a crisis team and he actively promotes “*having a laugh*”.

It was acknowledged by a couple of the interviewees that it may be difficult for people who are joining the team to fit-in because of the strong personalities

and the strong level of team cohesion. This point is succinctly illustrated by the following comment:

*“I think we’re the kind of team that’s better for knowing, so I think once people have stayed for a while, either we adapt to them or they adapt to us and they can kind-of blend in more”.*

### **Team development**

As previously mentioned, during the initial induction period for the team the team spent ten days together developing a model of how they were going to work. Since then, the team have away-days approximately once a year where they discuss the team’s vision and also operational issues that are on the horizon. These are forums for all staff to be consulted on impending changes. The team lead would prefer more regular away-days but this is not possible as it is necessary to provide their service.

The team lead has tried to put systems in place for formal team development but feels that the team (including himself) *“get sucked into the crisis and the busyness”*. He acknowledges that formal team development should not be neglected when he says *“it’s useful to step outside of things sometimes and get the team developing”*.

### **Continuing professional development**

The team lead is committed to the idea of both team and individual professional development. He impresses on team members the importance of continual learning and encourages training and clinical supervision. However, as seen in the case of team development, formal professional development is neglected because of the demands of delivering care. Again, the team lead recognises that people should make the time for professional development and he is *“really trying to get everyone doing something away from crisis just to hold on to that, whilst crisis is busy and important, there are other things like their own professional development that are also important”*.

The team lead will actively monitor people’s performance and will work with people more closely if he perceives them to be experiencing difficulties. If he believes that under performance is due to a bad attitude on behalf of the team member in question, he will be very direct and question why this is happening. If there is an understandable reason for the poor performance the person will be supported to improve, but if not the team lead will take a hard-line approach to monitoring and pushing the person to perform.

### **Team communication**

Apart from the team away-days, the team have daily clinical handover meetings and weekly team meetings to discuss operational business. This means that the team is kept informed and consulted on clinical and operational issues. There seems to be a consensus from within the team that

the team lead genuinely consults with team members and is sensitive to, and where possible, accommodates their wishes and alleviates their concerns.

From observing one of the clinical handover meetings, it was clear that this is a very good tool for organising people's work. The handover was very well organised and systematic, with everyone present concentrating and contributing to what was going on. At the end of the meeting there were clear action points that were delegated to relevant staff.

### **Team morale**

The commitment and motivation of the team lead and the other team members can not be overstated. It was clear from all the interviews that people are so committed, motivated and enthusiastic about what they do; as one of the team members said, *"all the team members give 110%"*.

When asked what makes the team effective, one of the support workers said:

*"Dedication, enthusiasm; when you're still excited about the job it will always runs well. You have to be interested and enthusiastic and once you loose interest and enthusiasm it would be like a domino effect, you would start to slack on everybody – it would just be a mess"*.

The team members joined the team because of their commitment and enthusiasm for crisis care. It is clear that the team lead is a driving force in maintaining this; he talked passionately about his job and the other team members attributed their continued enthusiasm partly to the team lead's obvious commitment and motivation. The team lead's motivating effect was clear from several of the comments made by the interviewees, the following comment is just one example: *"[...] because he's enthusiastic and committed he makes sure the team works the same. It's like follow your leader. I mean if he slacked we'd all slack – he does keep the team on its feet"*.

Whilst the team lead's enthusiasm and motivation has a positive effect on the team, something to be concerned about is what happens when he is not there. The team lead had to go on secondment for a few months and when he returned he felt there was a problem with morale. Other staff commented on this and one team member said about when he wasn't there: *"It ran itself but you could feel [team lead's] presence wasn't there. Because of the strong person that he is and because of his dedication, we all follow suit"*.

Just as the commitment and motivation of the staff are tangible, so is the job satisfaction. People really feel that they provided good quality care in the community, which they know is of great benefit to the users and carers. In short, the team members believe strongly that they are an effective crisis resolution team.



## **Relationships with external agencies**

Most people interviewed felt they had good relationships with other services in the area. Whilst they experience similar difficulties to other teams, such as inappropriate referrals from A&E and being asked to do things that are beyond their role, the team do not appear to have to make too much effort to maintain good relationships

The difference between this team and others in the effort required to maintain good relationships with external agencies could be due to a couple of reasons. The first reason is that the culture in the mental health services in L2's trust was at the outset, and still remains so, very positive about crisis work; The second reason could be that the mental health service in L2 does not seem to experience as many trust imposed changes as other teams. Continual change must make it difficult for the different agencies working in the Trust to establish clear and consistent ways of working together.

L2 approaches working with external agencies through:

### *Consultation and communication*

Through attending joint meetings and ward rounds.

### *Being flexible*

The team tries very hard to accommodate any requests external agencies have, even if they are beyond their role.

### *Being pragmatic*

The team lead was expecting there to be teething problems when they first set-up because as part of his planning process he visited other CRTs and this was the feedback he got; in this sense the team lead was pragmatic about potential difficulties because he recognised that difficulties would exist but was also aware that these would settle over time. The time element has been found to be a significant factor in building good relationships with external agencies and L2's lead found that it took approximately six months to establish good working relationships with other services. The time factor may be something that other teams do not have the advantage of due to the continually changing nature of the service.

The team are also pragmatic in the sense they acknowledge there will always be an element of friction when the teams are unable to meet requests made by external agencies.

### *Being respectful*

It is clear that the team has respect for the skills and experience of the other services working in the area, and there is definitely a sense that they have reciprocal relationships.

### *Shared working*

The team lead is keen that people from the other mental health services in the area cover some of their on-call shifts for them. This is helpful because it

leads to a greater understanding of each other's roles. The team also has people coming in to work with them for small periods of time which, again, aids in the understanding of roles.

### *Being assertive*

The team are committed and motivated to ensure that, where possible, people should be looked after in their own homes. If they feel that someone has been admitted to hospital inappropriately then they will strongly challenge this decision. This approach seems to have contributed to a change in culture in the area from one that was centred around hospital admission to one that is centred on home treatment.

## **Focus on Leadership**

### *Respect from the team*

The respect for L2's leader is very tangible. When the interviewees were asked "What makes a good leader?" the majority of staff referred to him as an example of a good leader. The following quote from one of the interviewees when asked to give an example of when the lead had been effective summarises the team's attitude towards the team lead:

*"Well, he's always effective [...] I mean I wouldn't say this to his face [laughing] but he is really, really good, and if you learn from him you learn from the best really".*

### *Inspiring and visionary*

It is evident from what has been discussed that the team lead has a clear vision and ensures that this is kept alive and adhered to in the day-to-day practice of the team. All the interviewees shared the same strong vision of what the team is and about the service it should provide, and they are motivated and committed to achieving this.

### *Commitment*

It is clear from what has been discussed that the team lead is extremely committed to his work and that this commitment permeates throughout the team, promoting commitment amongst the team members.

### *Motivating*

As with commitment, the team lead is very motivated and this motivation has a motivating effect on the other team members. It has been discussed earlier that the team may be quite reliant on the team lead for motivation, as when there was a temporary change in team lead there was "*a bit of a morale problem*".

### *Team focused*

The team lead is focused on the team as a unit and works to ensure that it is a cohesive group that work together to achieve the goals of crisis care. He will actively ensure that relationships in the team are good through addressing difficulties that he perceives. He also promotes the interests of the team to external agencies, and will work hard to ensure that these interests are

protected. Whilst there are some formal opportunities for the team to develop, the team lead recognises that these sometimes get neglected because of a focus on the immediate functioning of the team.

### *Supportive*

Team lead support was one of the clear themes that emerged from the interviews. He is very approachable and will offer support on professional and personal issues and, if necessary, the team lead will act as an advocate on behalf of the team member with regards to external agencies. One of the key elements of support is that the team lead will take ultimate responsibility with regards to clinical care; this is very reassuring for the team members and helps ease the burden of positive risk management.

### *Leading through example*

One of the key elements of the team lead's leadership strategy is that he believes it is crucial to lead through setting an example to the team; as the following comment from the team lead illustrates:

*"I am very keen on leading from the front. I do more on-calls than anybody and more late shifts than anybody. I'm in early. I've always been like that wherever I've worked but I think in particular here you need to have that. If you're going to lead something like this you need to do it from the front".*

This is a crucial factor in the *respect* that the team members have for the team lead. This is clear from the following comment made by one of the team members:

*"He wouldn't ask anybody to do anything that he wouldn't do himself. So you don't feel as if you're being put-upon – because he will do everything, if not more, than everyone else does, and it works".*

In this sense the team lead is visible clinically and managerially.

### *Firm but fair*

There was a definite sense from the team interviews that the team lead is very firm, and, as such, the team members know exactly what he expects from them and they are clear of the boundaries that they are working within. He will be very blunt with people and will often challenge the team and the individuals within it if he feels that his standards are not being met.

This firm approach is definitely accepted by the team members because they know that he is also fair. With regards to working hard, the team are expected to work hard for the majority of the time but then when there is time to relax, the team lead will let the team relax. With regards to the team lead challenging the team, it is also acceptable for the team members to challenge the team lead when they think it is appropriate. This final point is demonstrated by the following comment by one of the team members: *"because of the type of rapport we have you can say to him "look, hang on, you're not being fair".*

The team lead is also fair in the extent to which he tries to accommodate the personal needs of the team members; for example, he expects them to give 100%, but in return he will be flexible in meeting their shift requests.

#### *Forthright communication*

It is clear that the team lead is a very blunt communicator; he thinks nothing of swearing and is very comfortable with this approach. The following quote is an example of when he was recalling how he tries to avoid people going into hospital: *“I’ll be very, very assertive. I have a reputation for being quite forceful, almost petty actually, you know, almost taking it personally”*.

In this sense, the team lead does not appear to be as outwardly sensitive as other team leads. However, because the members of the team are also assertive and open communicators and also because the team lead is regarded as fair, the forthright communication style is accepted amongst the team members. However, it may account for why the team is *“better for knowing”*.

#### *Knowledge and skills to manage and develop the service effectively*

The team lead has been very competent in knowing what is required to manage and develop the service effectively. Ever since the team was in the planning phase of development, the leadership has known what to do to take the service forward. The team lead has been very good at recruiting the right staff, managing these staff, and building relationships with external agencies.

One of the key themes to have emerged from the interviews is how organised the team lead is and that was one of the reasons for their effectiveness as a team. As one of the team members said *“he gets things done and makes things happen”*. The team lead’s organisation was also very evident from the observations of the team.

#### *Very strong leadership*

It is clear from the interviews that the team lead has a very strong leadership style. His overwhelming commitment, motivation and competence mean that he is a very strong figure both within and outside of the team. He has a clear ideal of what he wants and makes sure that this is achieved.

While this is very positive, there is a sense that there might be an over-reliance on the team lead because of his strong leadership style. The team lead admitted that when he was away from the team there was a reduction in team morale, and other team members felt that this was the case also. He obviously makes decisions on behalf of the team and people look to him to do this, as the following comment from the team lead highlights:

*“Sometimes I think I do not allow people to grow professionally because I sit there and everything comes to me and goes back out again. I’m not always here so they have to get on with it themselves as well, and I do get pulled in to meetings. But when I’m here I like to be in*

*the office and in charge of things. And people look to me to make decisions”.*

Despite the above comment, the team lead is not autocratic; he will involve the team in the decision-making process and listen to their views and concerns.

#### *Collaborative and cooperative*

From what has been discussed, it is evident that the team lead will collaborate and cooperate with external agencies and service users and carers to ensure effective service delivery. One of the crucial elements of this is that he is flexible in his approach.

#### *Pragmatic*

The team lead is aware that sometimes there will be external initiatives that are not in the best interests of the team and that the team will have little control over. The team lead will not “catastrophise” at these times, instead he will remain motivated and look for solutions to the problems. Whilst doing this, he will be sensitive to the needs of team members and will work hard to ensure that their concerns are alleviated and their needs met.

### **Outcomes**

#### *Hospital Admissions Data*

The team only provided six months hospital admissions data, which is detailed in Table L2.2. The average percentage of people referred to the team that are admitted to hospital is 7%. The average number of people assessed by the team that are admitted to hospital is also 7%. This was one of the best performing teams with regards to hospital admission rates.

**Table L2.2**

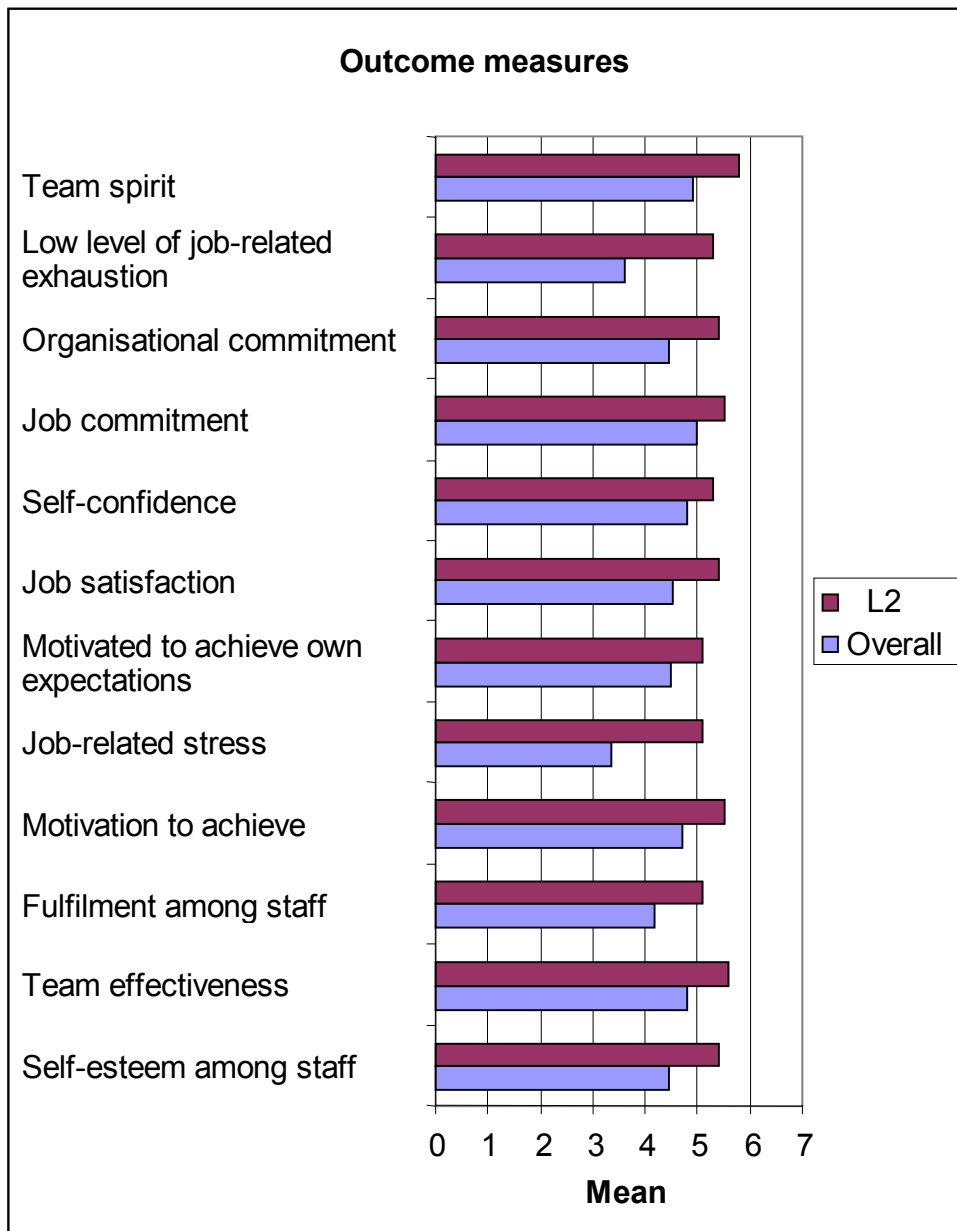
	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Apr-05</b>	30	30	3
<b>May-05</b>	30	30	1
<b>Jun-05</b>	30	30	1
<b>Sep-05</b>	30	30	4
<b>Oct-06</b>	30	30	1
<b>Nov-06</b>	30	30	2

#### *LCCI Outcome measures*

The LCCI outcome measures are presented graphically in Figure L2.2, with the more detailed results presented in Table L2.3. It can be seen from these that a positive picture has emerged. It is clear that the team is a confident team that works well together. It is also evident that there is a high level of commitment, satisfaction and motivation amongst the team members. The team also have less job related stress and less job-related emotional

exhaustion than other team members. It is particularly evident how positive L2's LCCI scores were when they are compared to the overall sample results

**Figure L2.2**



**Table L2.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>L2</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	10	5.40	0.52	<b>0.75</b>
Team effectiveness	725	4.78	1.12	10	5.60	0.52	<b>0.74</b>
Fulfilment among staff	717	4.17	1.26	10	5.10	0.74	<b>0.74</b>
Motivation to achieve	720	4.73	1.03	10	5.50	0.53	<b>0.75</b>
Job-related stress	712	3.35	1.47	10	5.10	0.74	<b>1.19</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	10	5.10	0.88	<b>0.56</b>
Job satisfaction	712	4.51	1.23	10	5.40	0.70	<b>0.73</b>
Self-confidence	714	4.78	1.02	10	5.30	0.48	<b>0.51</b>
Job commitment	718	4.98	0.93	10	5.50	0.53	<b>0.56</b>
Organisational commitment	719	4.46	1.07	10	5.40	0.52	<b>0.88</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	10	5.30	0.48	<b>1.18</b>
Team spirit	720	4.89	1.20	10	5.80	0.42	<b>0.76</b>

## **Conclusion**

As described above L2, is highly motivated and committed to achieving the vision of good quality, user-centred crisis care in the community. The team lead appears to be instrumental in the effective running of the service. He has a very strong leadership style that provides clinical, strategic and managerial guidance to the team. The team has been very effective at working with external agencies, which is assisted by the shared culture within the trust and the relatively stable environment in which they can deliver the service.

## Case study L3: Low admissions team

Six members of staff completed the LCCI at baseline. Although this is a low number, at the time the LCCI questionnaires were administered there were only nine members of staff in the team, so the response rate was 67%. Five team members were interviewed as part of the case study.

### **Context**

#### *Background*

Team L3 covers a mix of rural and suburban areas in the south east of England. The MINI score for the area is 0.66, indicating substantially lower than average mental health needs in the area. At the time of the case study, the team consisted of a team lead, seven CPNs, two of which were part-time, three support workers, one of which was part time, one part-time administrator, one part-time specialist registrar and one part-time consultant.

The team serves a population of 240,000. The average caseload ranges from 12-20 at any one time. There is no limit on caseload and the team will see cases for up to three weeks. The average percentage of service users with psychosis is approximately 12%.

At present the team has a partial gate-keeping function, but they are set to become fully gate-keeping in the near future. The team has access to a crisis bed in the private sector.

The team provides a 24-hour service, 365 days a year. The 24-hour period is covered by three shifts.

There has been no change in the team lead since the team's inception.

### **Setting up the team**

#### *Initiation of the team*

In 2004 an out-of-hour team was initiated. The current team leader was a member of the steering group during the development of the CRT and involved in the discussions of how this was to take shape. Based on the MHPIG an initial sum of £1.2 million was offered to develop the CRT. However, in practice only £655,000 was made available to do this, leaving the set up costs far short of what was expected. This shortfall in funding made it difficult to develop a CRT according to the MHPIG, particularly in terms of gathering together the required skill mix to deliver CRT services. This lack of skill mix has persisted during the course of the team's life.

The team lead researched home treatment alternatives, gate-keeping function and in-reach facilitation to see how these could be incorporated within the development plans of the CRT. The team lead did road shows to promote and inform external health and social care agencies of the impending CRT to be implemented in the area.



Once in post the team lead encountered a further 60% reduction in funding. This impacted negatively on instigating the necessary staff levels with the right skill mix to deliver CRT services. Nevertheless, the team lead managed to launch a CRT within the catchment area, but a very under resourced one.

#### *Planning the service*

The team lead was heavily involved in setting up the CRT, prior to commencing the post. Being part of the original steering group enabled input into the way the team could be set up and time to consider the plans for this.

#### *Working with the stakeholders to develop the service*

The team manager described having good relationships with various external stakeholders and joint working relationships with A&E department, the assertive outreach team, hostel providers, and a mental health consortium. Road shows conducted prior to the introduction of the CRT helped with this, particularly with GPs, which served to establish good communication channels with various external agencies and inform them of what the service aimed to achieve. Service users and other health and social care services were among the members of the original steering group involved in the development of the CRT.

#### *Initial staffing of the team*

The team lead is an experienced manager, having worked in NHS management for several years. As discussed earlier, the team lead did not have the funding to staff the team sufficiently with regards to numbers and skill mix. Despite this, the team lead was able to launch the service. However, soon after the service commenced, the team lead had to let half the staff go to work in another CRT in the same trust. The team lead had to make the most of whatever staff were left, which were a mixture of new and inherited workers. Initially there was also a stand-alone in-reach worker for the ward.

#### *Initial team development*

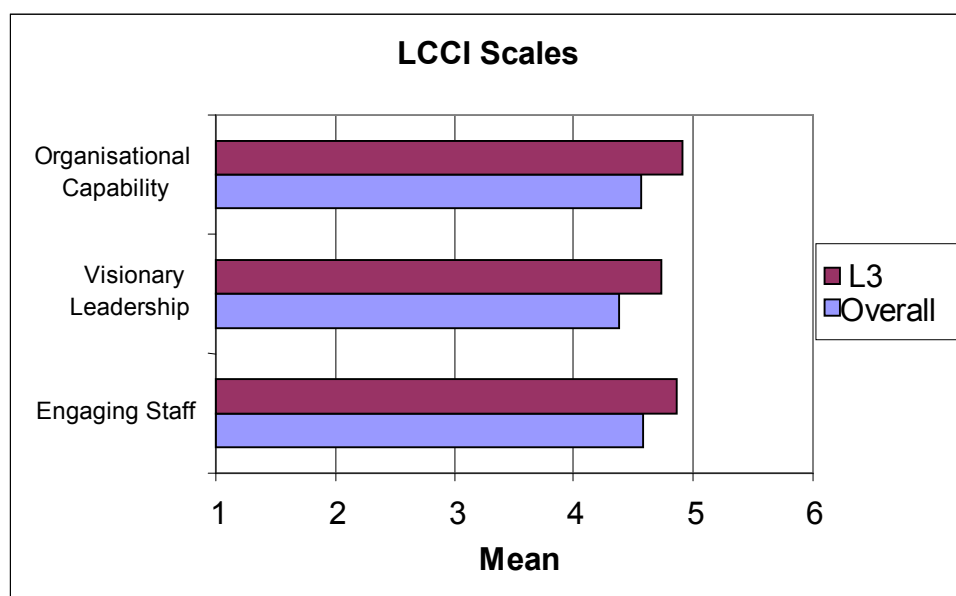
The team lead made every effort to develop the team with the limited resources available. Despite being a small team initially, with only 50% of the staff in post, the team worked to their full potential.

### **The Team**

#### *LCCI Scales*

The results for the three main LCCI scales are presented graphically in Figure L3.1. The detailed results are listed in Table L3.1 below. All LCCI mean scale scores were slightly below 5, indicating a moderately effective leadership culture within the team. The organisational capability of the team lead was scored the highest (mean 4.91, SD 0.56). The team considered their team lead to be engaging (mean 4.86, SD 0.57) and visionary (mean 4.73, SD 0.39). When compared to the LCCI scale scores for the overall sample, L3 scored more positively, with the effect size differences being small to moderate.

**Figure L3.1**



**Table L3.1**

LCCI Scales							
	Overall			L3			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	6	4.86	0.57	<b>0.32</b>
Scale 2 - Visionary Leadership	727	4.38	0.89	6	4.73	0.39	<b>0.39</b>
Scale 3 - Organisational Capability	728	4.56	0.79	6	4.91	0.56	<b>0.44</b>

### *Team Vision*

Of the team members interviewed as part of the case study, all shared the same primary aim and vision - to provide an alternative to hospital for people in crisis by treating them at home. The team lead elaborated on the vision held in terms of providing intensive crisis support. He was mindful of not taking on the full care coordination responsibility long term, and working as closely as possible with local CMHTs, and the system as a whole, to ensure good partnership arrangements. The team lead was keen to broaden this vision by introducing into their practice a recovery model of care and also improve service users' care pathways.

### **Composition of the team**

#### *Multidisciplinary*

The team itself was not only short staffed, but lacked the full range of staff needed for a multidisciplinary team. As described earlier, the team comprised of mainly nurses and support workers. Missing from the team were social workers, occupational therapists, psychologists, and a dedicated full time psychiatrist. In essence, this represents a serious shortfall, where the team

was unable to offer important support as far as social care, occupational therapy and psychological treatment were concerned.

Current deficits experienced by the PCT meant the team lead was restricted in appointing new staff. This situation acted to demoralise existing staff and left the team lead highly frustrated.

#### *Team expertise and experience*

Though the team is small in composition, the staff in post are highly experienced. The team lead in particular is an experienced manager. The qualified mental health nurses were a blend of highly experienced senior staff and relatively newly trained nurses. This was regarded as a 'good mix' by one of the support workers.

#### *Psychiatric input*

The team had access to a part-time specialist registrar supervised by a part-time consultant psychiatrist linked to the team. The specialist registrar was very new to the team and for the most part did medical reviews. This Specialist Registrar was aware of the different nature of the team compared to others.

#### *Gate-keeping*

The team has a fragmented gate-keeping role. This impeded the way the team could operate and made the process much more difficult. It resulted in having to work with many CMHTs, who tended to have the main gate-keeping role in the area.

#### *Team structure*

Nurses were a prominent feature of the team, with the team lead providing much if not all of the leadership. The hierarchy of the team reflected this feature with support workers at the bottom. Medical input from the part time specialist registrar had a specific role, but was limited in terms of clinical leadership to the team.

### **Relationships within the team**

The team lead was very positive about the team. The team appeared to work well together and provide support for each other. All members mentioned their team lead was supportive, having the necessary experience to lead them and be available to help when needed.

#### *Team development*

Currently the team has clinical meetings, business meetings and daily handovers, which is primarily when staff are together. The team leader uses these forums to pass on information and to develop the team. Time during meetings was also used to discuss any important issues. The team lead was conscious of the team not meeting as much as he would have liked.

### *Continuing professional development*

Individual supervision was provided to staff. All staff felt their training needs were mostly met. Support workers mentioned particular training needs around medication and risk assessment. Support staff expressed being well supported by the senior practitioners in the team. One was working towards training as a nurse.

### *Service development*

The team will undergo a complete reconfiguration. This will result in the night shift being stopped and the formation of a joint service with the acute inpatient service. This is happening partly to address many of the staffing and resource constraints experienced by the team since its introduction. Over the course of the team's life it has had four site moves, but its present accommodation is good. The team lead felt that the reconfiguration would take the CRT up to another level, allowing the team the freedom to remodel the service and be more creative with budgets. The team lead suggested some 'rotational' posts, in which staff worked for six months in the CRT and six months on the ward.

## **Relationships with external agencies**

As with the other teams, relationships were sometimes tense. Communication with other community mental health services (CMHTs and assertive outreach teams) was sometimes difficult. Not being fully informed by external agencies about a referred client was an issue flagged up by one practitioner. This would leave them working without much knowledge of the person, which often proved difficult.

Not having a full gate-keeping role exacerbated tensions with external agencies and prevented the CRHT from working in a whole systems way.

### *Relationship with the Primary Care Trust*

Perhaps the biggest source of strain was around funding for the CRT. The team lead was involved in discussions with the PCT to somehow resolve this difficulty.

## **Barriers to effective working**

### *Inappropriate referrals*

One of the biggest difficulties for the CRT is the inappropriate referrals they receive from CMHTs. All referrals to the CRT between the hours of 9am to 5pm came via the CMHT duty team who, prior to the CRT becoming involved, carry out a triage and assessment function. Should the referral not be deemed a crisis, the referral would be managed by the CMHT in line with established procedures. Following assessment by the CMHT duty team, if a crisis was identified which requires support outside what could ordinarily be provided by the CMHT then the referral would proceed to the CRT. The CRT will determine, based on the information provided by the duty team, whether a further assessment of need/risk should be arranged.

The team's caseload, thus, was mostly determined by the local CMHTs. As shown above, many of the referrals and subsequent uptake of clients were inappropriate. Some 65% of the entire team's caseload consisted of service users without a severe mental illness (SMI). Service users with a SMI only represented approximately 21% of clients taken on by the CRT. This is a critical problem, particularly in terms of meeting the MHPIG criteria and clients that should be targeted by the CRT. Although not included in the figures detailing the types of clients seen, many practitioners mentioned '*ending up with managing a lot of people with a personality disorder*'. It appears some of these service users were self referrals and would tell people in the team they were going to commit suicide in order to get help.

#### *Lack of gate-keeping*

This was out of the control of the CRT and considered a major problem by practitioners in the team. The team lead was keen to instil a gate keeping function and '*be the single point of entry*'. This would make working as a CRT, as envisaged by the MHPIG, much easier as far as the team lead was concerned.

#### *Communication problems*

At times the lack of communication from other multi agencies was a problem. The team lead explained problems surrounding lack of information provided by the CMHTs when they referred service users to the team. The CRT would prefer more information so the assessment process is not so time consuming.

Another communication problem between the CMHTs and CRT is the inability, due to the perceived lack of communication on behalf of the CMHTs, for the CRT to coordinate care with the CMHTs.

#### *Relief for the CMHTs*

One team member highlighted that very often there is a sense of relief for the CMHT when the CRT take on service users who have been on their books for a long time.

#### *Clarity of roles and responsibilities within the crisis team*

The team were very clear about what they ought to provide and the framework they were governed by. One of the senior practitioners spoke in terms of a role based on best practice and making sure all mental health service users could access the service 24 hours a day.

### **Focus on leadership**

This section examines some of the key leadership issues identified during the case study. It reveals how various members of the team perceived leadership and what they thought a good leader should be.

#### *Goal-oriented leadership*

For one senior practitioner a good leader represented someone who was focused on the goals of the team, yet aware of the development needs of their staff. An ongoing awareness of the training needs of staff was perceived as

part of this goal-oriented approach and a means by which the team could achieve the goals set.

#### *Clinical leadership*

A psychiatrist in the team emphasised the historical tension between the medical and nursing professions and how medical leadership fits into the context of the CRT. He suggested a joint leadership arrangement, although acknowledged the importance of the team lead's nursing background and experience in leading the team. This psychiatrist was more comfortable being led by his consultant, given they were from the same profession, and considered him a very good leader. Clinical leadership from the part time consultant psychiatrist appeared minimal.

#### *Knowledge and skills to manage and develop the service effectively*

Being the team lead of a CRT requires a lead to have many skills, including business skills. The business role the team lead had to adopt in order to negotiate funding from the PCT, and work with limited resources was considered 'uncomfortable'. Despite putting in a case for medical staff and an OT, the PCT was unable provide this. The team lead constantly had to find more creative ways of working but seemed tireless to fulfil this role. It was evident from interviews with other team practitioners that the team lead had generated a very good relationship with the senior management.

#### *Supportive leadership*

Being supportive and understanding was perceived as key to effective leadership. The team lead was described as having an 'open' style which allowed team members to approach the lead without difficulty. *"He is here everyday before anyone else. He is also not afraid to step in when we are short of staff"*. The availability and supportive nature of the team lead was highly regarded by one of the senior practitioners.

## Outcomes

### *Hospital Admissions Data*

Table L3.2 lists the figures for referrals, assessments and admissions with reference to L3. In the period between August 2005 and May 2006 the team experienced a very high number of referrals, sometimes in the region of 200 or more in a month. However, the number of assessments subsequently carried out was usually less than a third of the referrals made.

**Table L3.2**

	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Aug-05</b>	156	41	5
<b>Sep-05</b>	81	36	6
<b>Oct-05</b>	134	42	7
<b>Nov-05</b>	152	28	4
<b>Dec-05</b>	197	45	9
<b>Jan-06</b>	206	44	3
<b>Feb-06</b>	153	40	2
<b>Mar-06</b>	172	44	5
<b>Apr-06</b>	200	39	2
<b>May-06</b>	128	41	3

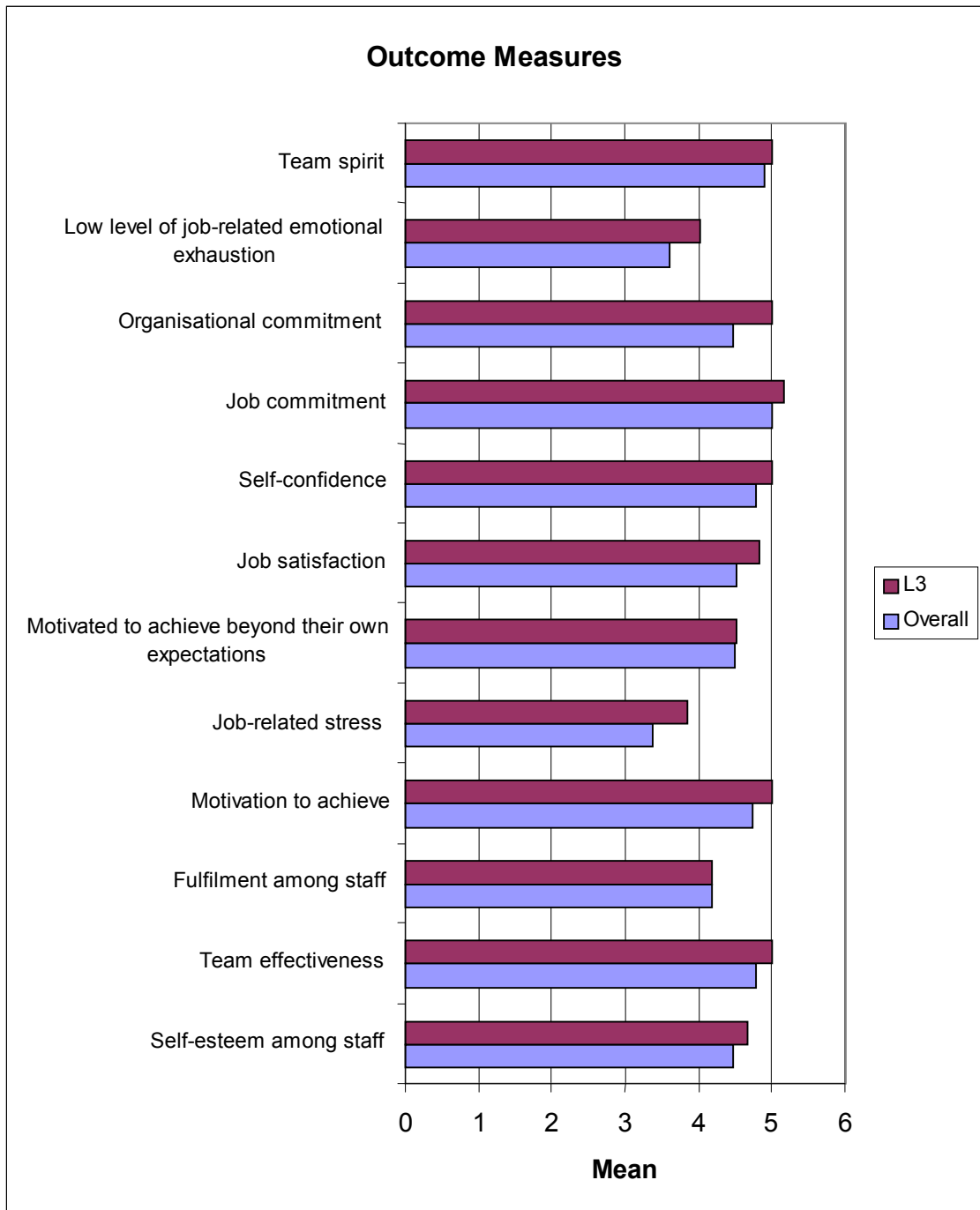
The overall numbers of admissions to hospital was very low considering the team's lack of gate-keeping function. The average percentage of people referred to the team and admitted to hospital was 3%. The average number of admissions in relation to the number of referrals assessed was much higher at 11%.

### *LCCI Outcome measures*

The LCCI mean outcome measures are shown graphically in Figure L3.2 and in detail in L 3.3 below. L3 slightly exceed the means for the overall sample on the outcome measures. Job commitment was rated highest in terms of outcome measures with a mean of 5.17 (SD 0.75). The team considered itself effective (mean 5.00, SD 0.63), motivated to achieve (mean 5.00, SD 0.63), confident (mean 5.00, SD 0.89), committed to the organisation (mean 5.00, SD 0.89) and high in team spirit (mean 5.00, SD 1.10). Job related stress had the lowest mean score (mean 3.83, SD 1.47)

When compared to the overall sample there was no effect size difference for staff fulfilment. The highest effect size difference was with organisational commitment at 0.51.

Figure L3.2





**Table L3.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>L3</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	6	4.67	1.03	<b>0.17</b>
Team effectiveness	725	4.78	1.12	6	5.00	0.63	<b>0.20</b>
Fulfilment among staff	717	4.17	1.26	6	4.17	1.17	<b>0.00</b>
Motivation to achieve	720	4.73	1.03	6	5.00	0.63	<b>0.26</b>
Job-related stress	712	3.35	1.47	6	3.83	1.47	<b>0.33</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	6	4.50	0.84	<b>0.02</b>
Job satisfaction	712	4.51	1.23	6	4.83	0.75	<b>0.27</b>
Self-confidence	714	4.78	1.02	6	5.00	0.89	<b>0.21</b>
Job commitment	718	4.98	0.93	6	5.17	0.75	<b>0.20</b>
Organisational commitment	719	4.46	1.07	6	5.00	0.89	<b>0.51</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	6	4.00	1.26	<b>0.27</b>
Team spirit	720	4.89	1.20	6	5.00	1.10	<b>0.09</b>

### **Conclusions**

It is clear from what has been discussed in L3's case study that, despite the team lead's efforts, the team has been plagued by a lack of funding, resulting in the team being under resourced with regards to staff numbers and staff skill mix. However, these resource issues appear not to have hampered the efforts of the team in terms of having low hospital admission rates. Whilst the lack of skill mix may not have had negative consequences for bed occupancy, it is not clear whether it may have hindered the range of interventions for intensive home treatment (i.e., the help with practical activities that ASWs and occupational therapists can offer).

One element of the functioning of L3 that has clearly emerged from what has been discussed is the lack of control the team has over the service users they treat; the CMHTs appear to dictate this. As such, the type of cases taken on by the team were mostly made up of people with depression and anxiety disorders and less in terms of those with a severe mental illness; perhaps this, to some extent, would account for the low admission rates.

## Case Study L4: Low admissions team

Six out of 15 members of the team completed the LCCI at baseline, making the response rate for the team 40%. Six members of the crisis service were interviewed as part of this case study.

### **Context**

#### *Background*

Team L4 is situated in the South East, a largely affluent area with pockets of deprivation. The MINI score for the area is 0.77, indicating substantially lower than average mental health needs in the area. The team has a total of 22 members, 21 of whom are full-time. There is a team manager for the crisis service as a whole, a team lead for the CRT, two psychiatrists, ten nurses, seven support time recovery workers, a senior self-harm liaison nurse, an ASW, an occupational therapist and a part-time administrator.

The team formed in December 2004. It serves a population of approximately 250,000. The average caseload size at any one time is between 15-20 cases. There is no formal limit on how long service users are seen by the team, but is usually between four and five weeks. The proportion of service users seen with psychosis is approximately 30%, which has remained the same since the introduction of the team.

The team has full gate-keeping responsibility and provides 24-hour care, 365 days a year. The 24-hour period is covered by three shifts.

This is a highly integrated service that includes not only the CRT, but an Intake Team, and self harm unit and the inpatient ward. If there is an imminent crisis the sector CMHT can refer to L4, so that they become involved in helping with preventing the crisis. GPs can only refer to the Intake Team during CMHT office hours, which then mobilises the CRT and ensures they start their involvement from the initial assessment. If the service user has a care co-ordinator this will be a joint assessment. If the service user is new to the service and is seen by L4, a care co-ordinator is appointed within two weeks.

### **Setting up the team**

The team was put together in a very short space of time, as soon as the budget for it had been agreed. Prior to the introduction of the team there was no crisis care in the area.

With the introduction of the team, commissioners of the Trust ordered the crisis service managers to close 50% of the beds in the inpatient ward. The outcome of this was described as positive, whereby more service users were then able to be supported out of hospital.

## The Team

### LCCI Scales

Figure L4.1 and Table L4.1 present the data for the three LCCI scale scores. It is striking that each score is below the overall mean LCCI scale scores, as demonstrated by the effect size differences (see Table L4.1). The lowest score was for engaging staff (mean 3.99, SD 1.31). However, the team appeared to be well organised and well run (mean 4.23, SD 0.87).

Figure L4.1

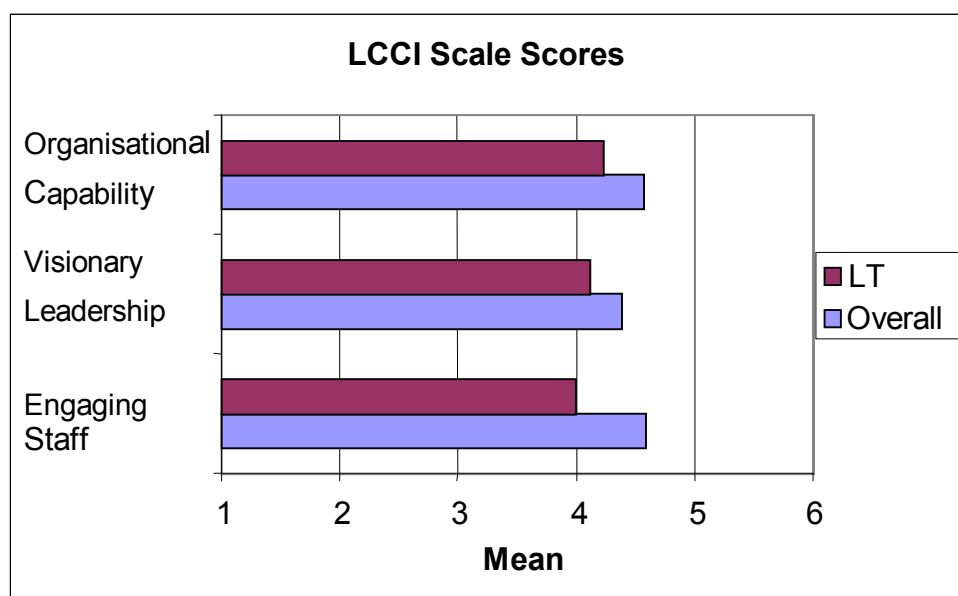


Table L4.1

LCCI Scales							
	Overall			L4			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	6	3.99	1.31	-0.69
Scale 2 - Visionary Leadership	727	4.38	0.89	6	4.11	1.23	-0.30
Scale 3 - Organisational Capability	728	4.56	0.79	6	4.23	0.87	-0.42

### Team Vision

The team's philosophy of care, values and principles was underpinned by the recovery model. In practice, this enables service users to identify their individual recovery needs, which include cultural, spiritual and social aspects. The team manager viewed the service as being composed of four parts (the crisis team, inpatient ward, self-harm liaison and intake assessment team) that worked in a whole-systems way. His responsibility was to ensure each part worked in unison with the other and that there were no gaps in service provision.

The recovery model runs through the main ethos of the team and the way staff work with service users. The emphasis is on establishing a good

therapeutic relationship and supporting the client to manage their lives in a meaningful and fulfilling way. This is a very positive practice and one the team are keen to deliver.

The team lead for the CRT specified the team's specific purpose as: an alternative to admission, early discharge from hospital, and prevention of relapse.

L4 did not consider itself a crisis team, and preferred to be called home treatment team. This was largely because of the recovery model used and sometimes continuing to see clients if the CMHT did not pick them up.

## **Composition of the team**

### *Multidisciplinary*

The team includes the full range of staff needed to operate a crisis service: team lead, nurses, a social worker, an OT, and a substantial number of support workers. Staff 'rotate' between the four service components. Some staff still retained their preferences towards either working on the ward or in the community, which occasionally created some tensions within the crisis service.

The service is highly flexible and staff can move to where the demand is. The roles of staff have become more generic. This was exemplified by the statement that '*there has been a sort of blurring of roles*' (Team Manager). However, specialist staff, such as the social worker, have not lost their specialist focus.

The role of the self-harm liaison was quite specific. Their aim was to work closely with the local A&E department and L4, do assessments with clients and identify the right support for them. This function also delivered psychosocial education.

### *Team expertise and experience*

The majority of staff in the team experienced crisis professionals with several years experience behind them. The team manager, as well as being an experienced crisis practitioner, has studied management at postgraduate level. This experience has enabled the team to function and adapt very quickly to the changes that took place when the new structure was introduced.

### *Full time dedicated psychiatrist*

The crisis service as a whole has two psychiatrists, one a full time consultant, who worked across the inpatient ward and CRT. Since the introduction of the new crisis service the psychiatrists no longer do traditional ward rounds, but instead conduct case reviews to make decisions about how best to apply the recovery model for clients. This approach from the psychiatrists shows an obvious commitment to the principles of crisis resolution.

## **Team structure**

With roles for most staff becoming more generic, the hierarchy of the team is likely to be largely flat, where more senior staff are either managers or psychiatrists. With the changes on the ward and the model of recovery introduced into the system of working, the medical hierarchy was virtually none existent. The support time recovery workers had relatively important roles, which were to assist with assessments and work closely with a service user's care co-ordinator from the CMHT to see them through their recovery.

### *Relationships within the team*

Relationships within the team were considered good. Initially relationships were tense, but as staff became more familiar with each other things improved. Staff were conscious of the decisions they made, knowing that it would impact on the other services. As the team manager put it "*staff were compelled to talk to each other and see themselves as one large team*". To do otherwise would have created tensions between staff in the different parts of the service. For all staff, the main motivating factor was the service user's experience. It was this clear focus that helped staff bond well and maintain commitment and enthusiasm towards their job.

## **Relationships with external agencies**

The team manager described relationships with external agencies (i.e., CMHTs etc) as '*not bad*'. This was an area the team had been working on to improve. He mentioned the main problem was what external agencies expected the team to do. Each external agency had different ideas about the role of the team and very often these ideas were outside the team's remit. As he put it, "*they want them [L4] to perform miracles 24hrs a day, be everywhere, do everything; and that seems a big challenge*".

Part of the team manager's initial work involved getting other services to change their view about what they delivered as a service. Informal visits to other teams were carried out. Open mornings or afternoons were arranged and the team attended meetings in other organisations as an observer. As a consequence, the team manager introduced changes to the referral systems and discharge procedures. This had a knock on effect on how other teams operated, and services were not able to refer to the team unless they were willing to follow the recovery model. This forced other services to change their practices if they wanted their service users to be taken on by the crisis service. In many ways the crisis service had led many of the wider changes in mental health care across the catchment area.

The self-harm liaison team was an interesting part of L4. This section of the service had formed working relationships with the A&E department, primary care services and local schools. Despite service users who self harm being outside the remit of the MHPIG, this team acted as support to L4 by offering education and social care expertise to clients. The main difficulty was the relationship this part of the team had with the general hospital. There was still

a “them and us” attitude and staff in the general hospital considered service users who self harm as “*time wasters*”.

It is likely that due to the integrated nature of the service and the whole-systems approach, especially with regards to inpatient care, the relationships with external agencies will not be as problematic for L4 as they were found to be for some of the other case study teams.

#### *Relationship with the PCT*

It would appear from what had been discussed that the team do not have a great deal of control over the directives that come from the PCT. It has been seen how the commissioners had instructed the team to close 50% of beds and were in many ways demanding. There are currently some proposals to absorb the team back into the CMHT, which the team lead did not consider a good idea. For it to work the CMHT would have to change dramatically or there was a risk of the service going backwards.

### **Difficulties with multi-agency working**

#### *Approach to building good relationships with external agencies*

The most successful approach to building good relationships with external agencies included proactive attempts by the team lead to promote the service. This very often involved attending meetings and arranging drop in sessions for staff from other agencies.

#### *Difficulties with integrated working*

The team manager felt his role involved keeping the gap between each of the service components as tight as possible. However, part of the team’s role was to manage the inpatient beds, particularly since the bed closures were introduced and with the retirement of the bed manager. This was a time consuming activity for the team and they found that much of their thinking revolved around managing beds.

### **Focus on leadership**

#### *Empowering leadership*

The team manager had some interesting ideas about what leadership meant for staff in the service. It was important staff were supported to then create an environment in which they could thrive. As he explained:

*“When staff feel they can flourish and are supported to do this, they will in a sense manage themselves. What we have within each team is a sort of micro system so staff are empowered to make changes on a daily basis to suit the demand at the time”.*

Interlinked with this form of leadership is giving staff autonomy and responsibility to make decisions as and when necessary. Staff were considered to be in a key position in which to carry out such decision making. The team manager saw his role as that of managing the whole team and the four parts within it, ensuring there were no spaces in between.

### *Visionary leadership*

It is clear from what has been discussed that the team lead has a clear vision for the service that is a user-centred integrated approach. As the team works together with the other acute mental health services, it seems that the vision and the philosophy of the team is very much a reality.

### **Outcome measures**

#### *Hospital Admissions data*

L4 had the lowest admissions rates of all the case studies carried out. Admissions to hospital were particularly low for team L4 with only 2 admissions noted in an eight month period (see Table L4.2). All referrals to the team were assessed. The proportion of admissions in relation to the number of assessments and referrals was 0.4%.

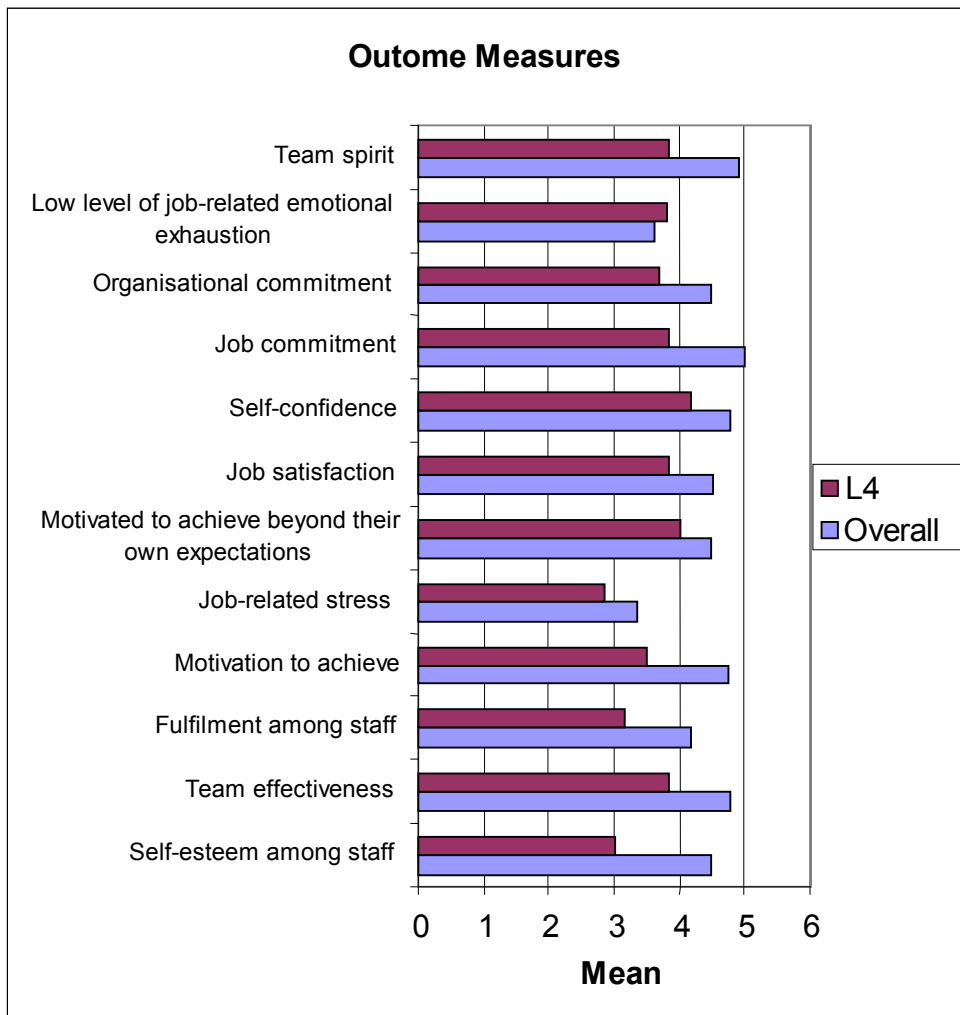
**Table L4.2**

	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Dec-05</b>	74	74	0
<b>Jan-06</b>	52	52	1
<b>Feb-06</b>	50	50	0
<b>Mar-06</b>	55	55	0
<b>Apr-06</b>	38	38	0
<b>Jul-06</b>	76	76	0
<b>Aug-06</b>	76	76	1
<b>Sep-06</b>	101	85	0

### **Outcome measures**

L4 was a reasonably confident team (mean 4.17, SD 0.98) and fairly motivated to achieve more than members expected of themselves (mean 4.00, SD 1.26). All outcomes were lower than the overall sample as shown in the effect size differences (see Figure L4.2 Table L4.3). Job related stress was particularly low (mean 2.83, SD 1.47). Similarly, self-esteem among team members was also low (mean 3.00, SD 1.55). This is interesting given staff appeared quite motivated to achieve (mean 3.50, SD 1.64). However, all the outcome scores listed were lower than the same scores for the overall sample.

Figure L4.2





**Table L4.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>L4</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	6	3.00	1.55	<b>-1.16</b>
Team effectiveness	725	4.78	1.12	6	3.83	1.60	<b>-0.85</b>
Fulfilment among staff	717	4.17	1.26	6	3.17	1.47	<b>-0.79</b>
Motivation to achieve	720	4.73	1.03	6	3.50	1.64	<b>-1.19</b>
Job-related stress	712	3.35	1.47	6	2.83	1.47	<b>-0.35</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	6	4.00	1.26	<b>-0.43</b>
Job satisfaction	712	4.51	1.23	6	3.83	1.72	<b>-0.55</b>
Self-confidence	714	4.78	1.02	6	4.17	0.98	<b>-0.60</b>
Job commitment	718	4.98	0.93	6	3.83	1.60	<b>-1.23</b>
Organisational commitment	719	4.46	1.07	6	3.67	1.51	<b>-0.74</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	5	3.80	1.92	<b>0.13</b>
Team spirit	720	4.89	1.20	6	3.83	1.60	<b>-0.87</b>

## **Conclusion**

This was a relatively well staffed team divided into four components. Staff were rotated between the inpatient ward and home treatment team. It had the lowest admission rates of the teams in which case studies were conducted. Gate-keeping was a core function of the team. So too was the recovery model which gave service users support to manage their lives in a meaningful way. Despite these positive attributes, the team had relatively 'poorer' LCCI Scale and outcome scores compared to the rest of the sample and some of the teams with higher admission rates.

It is not clear from the case study information why the LCCI scores are so low, so any discussion of this can only be speculative. One area to consider could be that since the team lead is, in effect, managing four services at the same time, he may be too distant to provide a strong sense of leadership to the team members. It could also be that people's sense of leadership in the team may have little bearing on hospital admission rates, as what might be the crucial contributing factor to these low rates is the truly whole-systems way in which the team functions. Finally, the low number of questionnaires completed may provide unrepresentative views of leadership within the team.

## Case Study L5: Low admissions team

Seventeen out of 36 members of staff completed the LCCI™ at baseline, making the response rate for the team 47%. Seven members of the team were interviewed for this case study.

### **Context**

#### *Background*

L5 is a CRT based in the north of England. It spans across three PCTs and serves a mixed demographical population. The MINI score for the area is 1.04, indicating average mental health needs in the area. There are 27 full-time staff and six part-time staff in the team, of which there are: 24 RMNs, 8 support workers, and one administrator. The team has two formal sessions a week from a consultant psychiatrist. The team has been in existence since March 2004.

L5 serves a population of approximately 450,000. The average caseload is extremely high at 75-80 service users at any one time and there is no declared limit on how many service users the team can see. There are no strict criteria on how long service users are seen for. The average proportion of service users with psychosis is ten percent.

The team is partially gate-keeping. Psychiatrists can still admit directly to the wards, although this is set to change over the next few months. The team provides 24-hour care, 365 days of the year. The 24-hour period is covered by three eight hour shifts.

Since the team has been in existence there has been no change in team lead.

### **Setting up the team**

#### *Initiation of the team*

The team was initiated by the PCTs in the area in response to the MHPIG. Prior to the introduction of the crisis team there was no community based crisis resolution work in the district.

#### *Planning the service*

The team lead got his position through responding to an advertisement. Since there was no team in existence, all he had was “*the PIG report and an empty box to go on*”.

The team lead had approximately six months to plan and develop the service. He started the process by doing a gap-analysis to see what was available in the area in terms of crisis care. He then visited existing CRTs around the country to establish an idea of what works and does not work with regards to delivering crisis care. As he was designing the model he set up a steering group with representatives from the PCTs, users and carers, and the other agencies affected by the service. He consulted with these key stakeholders to shape the service to be delivered.

Once he had formulated a model he presented this to the PCTs. The estimated costs of this model exceeded the funds available, so it was decided there would be a phased implementation of the ideal model, with the initial phase reflecting the immediate priorities.

#### *Initial staffing of the team*

The team lead was in control of the staff he recruited. He initially advertised for 14 senior RMNs. There was a great deal of interest in the positions, so he was able to recruit some excellent staff who were committed to the principles of CRT. The staff he recruited primarily came from the acute hospital wards in the area, which straight away caused friction between the wards and the CRT.

#### *Initial team development*

Prior to starting the service the team had a two-week induction period. At this time they worked out their operational policy and focused on the aims and goals of the team. They all had the same vision and they used this time to plan how this would work in practice. They also had training on the solution-focused approach to care, which is a model the whole team subscribe to.

#### *Service development*

As mentioned earlier, the team lead had to agree on a phased implementation of the service. The first phase was providing a purely crisis service, which involved assessing service-users and treating them in the community for up to 72 hours. After a year, funding was available for phase 2 of the service delivery, which extended the length of care the team was able to provide from 72 hours up until approximately five weeks. This involved recruiting 26 more members of staff of lower grades (D and B grades).

## **The Team**

#### *LCCI™ scales*

The results for the three main LCCI scale are presented graphically in Figure L5.1. The detailed results are listed in Table L5.1. It can be seen from these that L5's scores are very similar to those of the overall sample, with only very small effect-size differences. The means for the LCCI scales are all above four ('Engaging staff'  $m=4.54$ ,  $SD=0.80$ ; 'Visionary leadership'  $m=4.27$ ,  $SD=0.67$ ; 'Organisational Capability'  $m=4.58$ ,  $SD=0.63$ ), which is indicative of effective leadership within the team. It is interesting that although the effect-size is only small, the team results show a poorer score than the overall sample on the 'Visionary leadership' scale.

Figure L5.1

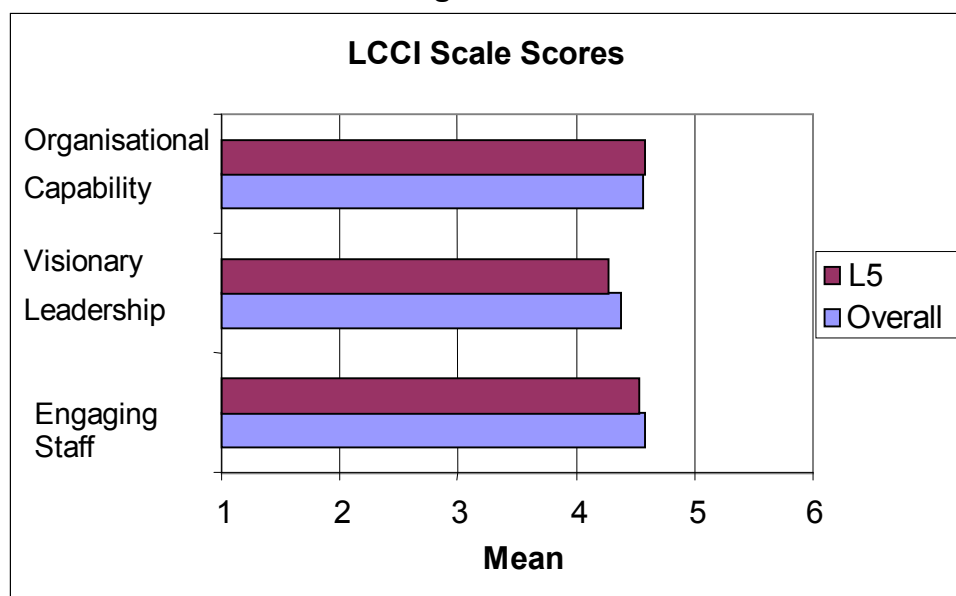


Table L5.1

LCCI Scales							
	Overall			L5			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	17	4.54	0.80	-0.06
Scale 2 - Visionary Leadership	727	4.38	0.89	17	4.27	0.67	-0.12
Scale 3 - Organisational Capability	728	4.56	0.79	17	4.58	0.63	0.02

### Team Vision

It is evident from the interviews that there is a very clear vision of providing good quality, solution-focused care for people in their homes. As with the other teams, their approach is user centred, and all operations are framed in terms of what is best for the user and carers. Key elements of the team's vision are to be holistic in nature; taking into account the social and relationship factors that affect people's mental health. Also central to the team's vision is that it is a nurse-led service, as apposed to a medically led service. One of the interviewees who was new to the team felt that the strong user-centred and holistic philosophy in the team was exceptional in the trust, as most of the other areas she had worked were very medically focused, where the best interests of the service-user were often not the main priority; these were the key reasons why she wanted to work in the team.

There is certainly a shared sense of vision amongst the team members, which is partly due to recruitment and partly due to vision development within the team. When the team lead recruits staff, one of his requirements is that they share the same philosophy of care as the team. This vision is then shaped and communicated through discussion at away-days and clinical handovers, and through informal methods of communication. The team lead believes it is important for everyone in the team to have a shared philosophy.

There is a strong solution-focused model of working within the team. This approach is signified by managing risk through looking at people's strengths and coping resources (solutions) rather than just looking at the problems (such as wanting to self-harm). The team lead ensures that everyone subscribes to this approach and that they have the skills to implement it.

The strong vision evident in the interviews appears inconsistent with the LCCI scores which, as discussed earlier, showed a slightly lower score for the team when compared to the overall sample on the 'Visionary leadership' scale.

## **Composition of the team**

### *Team expertise and experience*

The team was originally made up of senior practitioners that had a great deal of experience of acute care to be able to carry out assessments. Again, this was helpful with risk assessment. As the service developed to include home treatment, junior qualified and unqualified staff were employed to carry out the home treatment role.

### *Lack of disciplines in the team*

The team consists of RMNs and Support Time Recovery Workers (unqualified health workers). As such, the team is lacking in the other disciplines (e.g., social workers and occupational therapists) that the other case-study teams felt were advantageous to service delivery.

The team lead has tried to recruit other disciplines, in particular social workers, but has found this difficult due to funding issues between the NHS and Social Services. Social workers are interested in working in the team, but the level of experience they require to work there means their salary is substantially more than experienced NHS staff. A social worker is due to start in the team soon, and this person is prepared to compromise on their salary in order to work there.

It is not clear to what extent the lack of disciplines in the team affects the service available; the low hospital admission rates would indicate that it is not detrimental. This could be due to that, although the majority of the team are nursing staff, there are a variety of approaches within this, including cognitive behavioural therapy, psychosocial interventions and solution-focused interventions.

### *Psychiatric input*

The team has a consultant psychiatrist for two sessions a week. It is not felt that a higher level of consultant input is required since the service is practitioner led; the team will consult the psychiatrist only if they feel it is necessary.

The team initially had problems getting dedicated medical cover as the consultants in the area were quite opposed to CRTs. Apart from the CRT, there appears to be a very strong medical approach to mental health services

in the area, with decisions being made by the consultants; hence the opposition to the team. They managed to secure a consultant through demonstrating that the lack of consistent medical input was not advantageous to any parties.

The consultant they have working with them is now committed to the philosophy of the CRT as it is clear that it is effective. This had been advantageous for the CRT as this consultant promotes the work of the team to the other consultants and on the wards. It is this, and the fact that there is now evidence to show the team is effective, that has eventually led to better relations between the CRT and medical staff; however, these relations are still considered to be 'politically' problematic by the team lead and other team members.

### **Team structure**

The team lead is not hierarchical in his approach, with the majority of issues that affect the team being discussed within the team, and solutions formulated as a team. The team lead tries to facilitate the team to make decisions so that they have a sense of ownership and engagement with what is happening within the team.

There does appear to be a clearer hierarchy in L5 than there was in some of the other case study teams. As can be seen from above, there are different grades of staff within the team, signifying differences in experience and role. The team does try not to be hierarchical, for example, senior staff will not dictate workload etc. to the junior staff; however, there was an acknowledgement by a senior practitioner that a hierarchy does exist, which cannot be denied as sometimes it is necessary to be hierarchical.

### **Relationships within the team**

Relationships in the team seem to be, on the whole, very positive; many of the interviewees commented on the exceptional support and respect they receive from their colleagues.

The job is pressured and the team is a large team based in very small office accommodation, so at times relationships can be a bit strained. According to a couple of the interviewees, there are colleagues who do not 'get-on', but that this does not interfere with the functioning of the team.

When the home treatment element of the service commenced, this new structure did create difficulties for the team, as the team more than doubled in size and new roles were added. As such, the team went from being a close knit group where the individuals in the team had clear and similar roles, to a much larger group where the addition of the home treatment service had blurred the role and responsibility boundaries; the team lead and the other interviewees felt that this created divisions within the team. The team lead tried to address this by having regular away-days so that the team could work collectively on the vision of the team and the roles and responsibilities of the

different groups of staff to achieve this vision. He was also keen to try and encourage staff not to avoid conflict through acknowledging that it is acceptable to have disagreements.

### **Team development**

As previously mentioned, during the initial induction period for the team L5 spent ten days together developing a model of how they were going to work. Since then, the team have regular away-days where they discuss the team's vision and also operational issues that are on the horizon. As mentioned previously, the team lead uses these days to discuss issues with the team collectively and to problem solve as a team in order to formulate a collective response to any difficulties that have arisen or that are arising. The team lead is very solution-focused in his approach to problems, and he promotes this philosophy throughout the team. He aims to engage the team so they have a sense of ownership on what is happening in the team.

With the team having distinct groups of staff with different roles and responsibilities, the team lead occasionally has separate away-days for these groups of staff so as to *“address their particular issues and concerns”*.

There are forums for the team to discuss clinical issues that they may be experiencing. When the team initially started they had formal group clinical supervision in order to discuss issues and concerns about particular cases, which was very useful from a risk-management perspective. As the team developed and became more comfortable with crisis resolution work, formal group supervision was no longer required. On a daily basis, the team have three clinical handovers a day where cases are discussed in depth; this acts as a type of group clinical supervision.

### **Continual professional development**

The team lead is committed to the idea of both team and individual professional development. He impresses on team members the importance of continual learning and encourages training. One thing he is clear about is the importance of clinical supervision, which he regards as essential.

One good example of the team lead's approach to professional development has been the expansion of the role of the support workers into support time recovery workers. This is a much more autonomous role for this group of staff, and the team lead has given them the freedom to develop and embed the role themselves; this has been very rewarding and challenging for the support time recovery workers.

There was a suggestion by a couple of the interviewees that the team lead was not very proactive in addressing poor performance issues that may arise with particular members of staff. People may be allowed to get away with underperforming for longer than they should, which in-turn has a negative effect on the rest of the team; this can be quite frustrating at times.

## **Team communication**

As can be seen above, formally the team have regular away-days and three times daily clinical handover meetings. These are forums where people can discuss openly concerns and difficulties. The team lead tries to promote a culture of transparency.

Informally the team communicate well together, ensuring supportive relationships within the team.

## **Team Morale**

There is a clear sense that people are committed and motivated to achieving the vision of the team. However, a couple of the interviewees suggested that there is negativity and cynicism amongst some of the senior practitioners who have been in the team since the beginning (largely due to difficulties experienced working with external agents). This, according to a couple of interviewees, is negatively affecting the morale of the rest of the team. There seems to be an element of frustration with the team lead, as the problem is not addressed.

Apart from this, team members do feel satisfied that they are providing good quality care for people in their homes and, as such, are achieving their vision.

## **Relationships with external agencies**

The relationships with external agencies seem to be very problematic for the team. There are the same problems evident that have reoccurred throughout the case studies, such as inappropriate referrals and an underestimation of the level of risk the team can manage. An additional problem that arose in this case study that was not present in others is that the majority of the CRT was recruited from the acute wards, which created bad feeling due to the skills shortage that resulted from this. However, the main problem that seems to affect the relationships between the team and, in particular, ward staff and consultants is the real domination of the medical model that is inherent throughout the mental health services in the area.

The difficulties with medical staff have already been touched on above. Since the wards appear to be led by the consultants, the negative attitude of the medical staff towards the crisis team has, in the past, created a culture of negativity towards the team. However, the team has worked hard to strengthen relationships with external agencies, and have seen a significant improvement in the culture due to this.

The approach the team lead and the team have to working successfully with external agencies is through:

### *Implementing the service incrementally*

Although the phased implementation of the service has been primarily due to funding issues, the team has deliberately phased in some aspects of the



service, such as gate-keeping, to try and ensure commitment from the relevant agencies, rather than forcing something on them that they do not want. It is only now that the team feel it is appropriate to go fully gate-keeping, as the politics involved with the consultants at an earlier point would have made service delivery very problematic.

#### *Consultative but assertive if required*

The team has taken a consultative approach to developing and running the service. They work with key stakeholders to try and deliver a service that reflects the stakeholder requirements. However, when there is a clear disparity between the vision of the CRT and the vision of the stakeholder, such as the consultants, the team will be assertive in trying to ensure that what is best for the service-user is achieved.

#### *Flexibility*

The team adopt a flexible approach in order to try and accommodate the requests of the external agencies. However, this does cause problems as there does not seem to be much consistency within the team on how much flexibility is given. This leaves the external agencies unclear about the boundaries of the CRT service.

#### *Attending shared forums*

Members of the team attend joint acute care forums. Ideally they would like to attend ward rounds but this is impossible because they have too many ward rounds a week. The inability of the team to attend ward rounds is a shame, as that would be one way of reminding the ward staff and consultants “*that there is another option*”. The team lead does visit the wards reasonably regularly to remind them of the aims and goals of the service.

#### *Improving understanding from within*

This is not a specific approach on behalf of the team, but having a consultant and a ward manager who have worked for the team help in promoting the CRT on the wards. The ex-team member, who is now a ward manager, said that she is slowly changing the culture of the ward to one that is aligned with the philosophy of crisis resolution.

#### *Being cooperative and respectful*

When the team get an inappropriate referral from an external agency, they are sensitive to the external agency’s perspective and situation and, if unable to accommodate their request, will sign post to an alternative agency in a constructive manner.

#### *Being Pragmatic*

As with other case study teams, the team lead and the rest of the team appear to be quite pragmatic in recognising that you can not please all people at all times. Disagreements on a particular issue fit into the broader picture, which, on the whole, is one of positive relationships that evolve over time.

## **Focus on leadership**

Evidence of leadership is permeated throughout what has already been discussed in this case study. It is useful at this point to bring together the key elements of leadership that have emerged from the research in the team.

### *Respect from the team*

The team obviously respect the team lead, especially for his approachability, guidance and support; these elements of the team lead's behaviour were also core to people's perceptions of what makes a good leader. They also respect how he is taking the service forward. The interviewee who has moved-on from the team to become a ward manager said that "[team lead] has been a superb role model in how I've gone on to manage the ward".

The one area that the team lead appears to fail to have respect is with regards to the perceived lack of constructive performance management for 'difficult' team members.

### *Visionary*

It is evident from what has been discussed that the team lead has a clear vision and ensures that this is kept alive and adhered to in the day-to-day practice of the team. All the interviewees shared the same strong vision of what the team is and about the service should provide, and they are motivated and committed to achieving this.

### *Commitment*

The team lead is extremely committed to his work, so much so that he is currently getting paid at a level lower than he is working.

### *Motivating*

The team lead appears to motivate the staff with regards to achieving the vision of the team and also with respect to achieving their individual goals.

### *Team focused*

The team lead is focused on the team as a unit and works to ensure that it is a cohesive group that work together to achieve the goals of crisis care. He will also promote the interests of the team members externally. For example, most of the team did not achieve what they felt to be the appropriate band in the Agenda for Change review; the team lead has worked on their behalf to try and ensure this is successfully reviewed.

### *Supportive*

Team lead support was one of the clear themes that emerged from the interviews. He is very approachable and will offer support on professional and personal issues and, if necessary, the team lead will act as an advocate on behalf of the team member with regards to external agencies

### *Knowledge and skills to manage and develop the service effectively*

From the start the team lead has had a very clear vision of how he wanted the team to function, and he has developed the service to reflect this. Through

consultation with stakeholders and team members, he has thoroughly planned the implementation of the service and has ensured that these plans come to fruition.

#### *Political awareness*

The team lead is very aware of the politics surrounding the service provided by the CRT. He will play a political game, especially with regards to medical staff (*he 'panders to their egos'*), in order to achieve the goals of the team.

#### *Facilitative leadership style*

It is clear from the interviews that the team lead has a facilitative and democratic leadership style. He encourages open discussion and debate, and has a team based, solution-focused approach so that people have ownership of what is happening in the team. It is also clear that the team lead facilitates people to have autonomy and control; he will also oversee the running of the team and provide support where necessary, but will not get engrained in minute details.

#### *Collaborative and cooperative*

From what has been discussed, it is evident that the team lead will collaborate and cooperate with external agencies and service users and carers to ensure effective service delivery.

### **Outcomes**

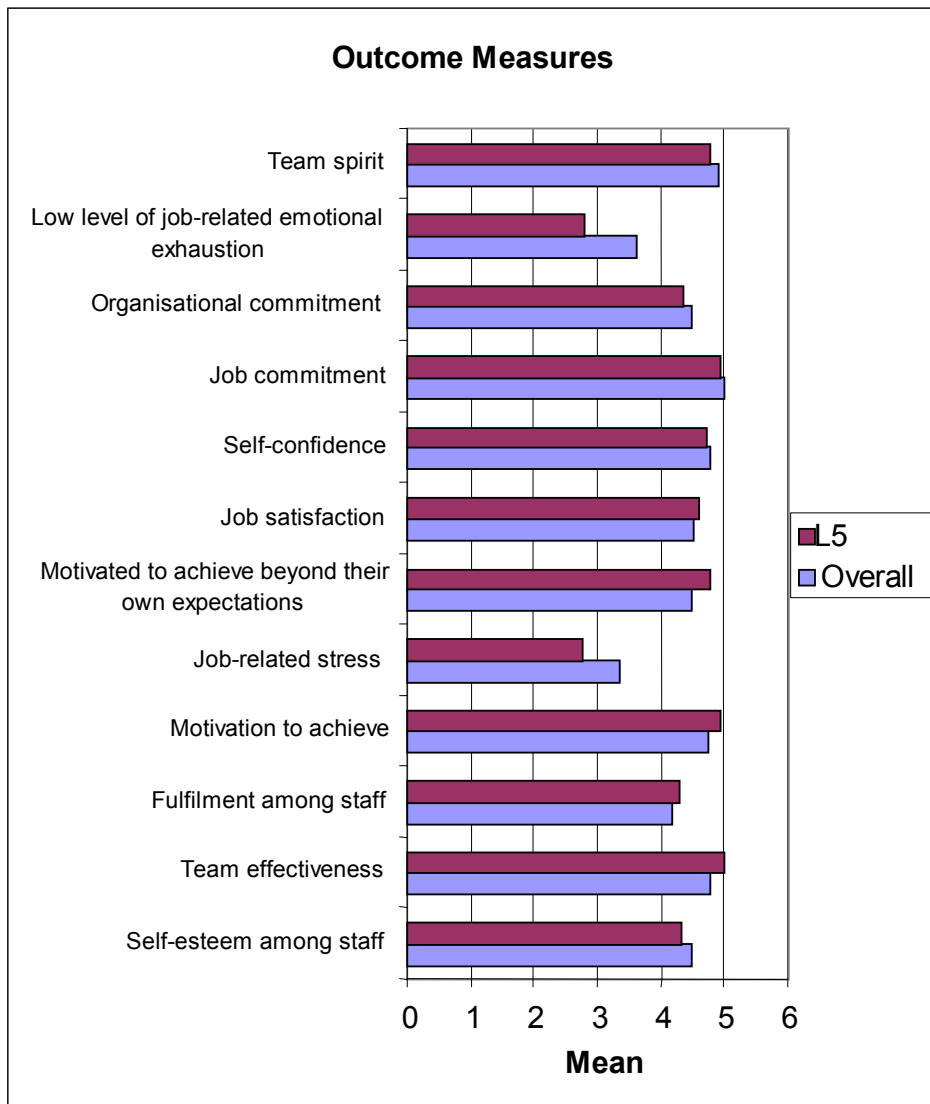
#### *Hospital Admissions Data*

Due to difficulties in ascertaining month-by-month admissions data, L5 provided an average of their hospital admissions data. The average percentage of people referred to the team that are then admitted to hospital is 6%. The average number of people assessed by the team that are subsequently admitted to hospital is 7%.

#### *LCCI Outcome measures*

The LCCI outcome measures are presented graphically in Figure L5.2, with the more detailed results presented in Table L5.2. It can be seen from these that the results are generally positive and inline with the overall sample results. A picture emerges of a team with a strong sense of effectiveness ( $m=4.74$ ,  $SD=0.75$ ), team spirit ( $m=4.94$ ,  $SD=0.92$ ), motivation ( $m=4.82$ ,  $SD=1.04$ ) and job commitment ( $m=4.74$ ,  $SD=0.93$ ). The team scores poorly on the job related stress ( $m=2.42$ ,  $SD=1.09$ ) and emotional exhaustion ( $m=3.06$ ,  $SD=1.35$ ) outcomes, especially in relation to the overall sample, indicating that they feel under a great deal of pressure.

**Figure L5.2**



**Table L5.2**

LCCI Outcome Measures							
	Overall			L5			Effect size differences
	N	M	SD	N	M	SD	
Self-esteem among staff	721	4.46	1.25	16	4.31	0.95	<b>-0.12</b>
Team effectiveness	725	4.78	1.12	17	5.00	0.87	<b>0.20</b>
Fulfilment among staff	717	4.17	1.26	17	4.29	1.16	<b>0.10</b>
Motivation to achieve	720	4.73	1.03	17	4.94	0.66	<b>0.20</b>
Job-related stress	712	3.35	1.47	17	2.76	1.03	<b>-0.40</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	17	4.76	0.83	<b>0.26</b>
Job satisfaction	712	4.51	1.23	17	4.59	1.28	<b>0.07</b>
Self-confidence	714	4.78	1.02	17	4.71	1.16	<b>-0.07</b>
Job commitment	718	4.98	0.93	17	4.94	0.83	<b>-0.05</b>
Organisational commitment	719	4.46	1.07	17	4.35	0.70	<b>-0.10</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	15	2.80	0.86	<b>-0.56</b>
Team spirit	720	4.89	1.20	17	4.76	1.39	<b>-0.10</b>

## **Conclusion**

From the case study a picture has emerged of a team that is very committed to providing user centred, community crisis care. The team lead is respected by the team and has been a strong figure in developing a service that is consistent with the vision of the team. The team lead has a supportive, democratic and facilitative approach to managing staff in the team, which the members of the team are grateful for.

The very strong dominance of the medical model in the other mental health services in the area has been very problematic for the team. Despite this, the team work hard to try and change the culture, which does appear to be slowly changing. The team are very aware of the politics surrounding the achievement of their goal.

## Case Study H1: High admissions team

Sixteen out of 42 members of the team completed the LCCI at baseline, making the response rate for the team 38%. Seven members of staff were interviewed as part of this case study.

### **Context**

#### *Background*

Team H1 is based on the East coast. The MINI score for the area is 1.04, indicating average mental health needs in the area. This is a large team comprising of a team lead, ten senior practitioners, eleven RMNs, three senior support workers, an ASW, a senior occupational therapist, a technical instructor, a part-time art therapist, a part-time pharmacist, an acute care service manager, a consultant psychiatrist, a Specialist Registrar, a Senior House Officer, a Trust grade doctor and two administrators.

This CRT was originally created in 2003, and re-formed in July 2005 as a new service under a mental health partnership for acute services. The team serves a population of approximately 220,000. The average caseload size at any one time is 25. There is no limit on how long service users are seen for by the team. The proportion of service users seen with psychosis is 40%; this level has decreased since the service began.

The team provides a 24-hour service, 365 days of the year. It is the single point of access for acute mental health services in the area, and, as such, it is responsible for conducting assessments and determining the most appropriate way of supporting the service user through the acute phase of their illness. The CRT and the inpatient wards are integrated, and have a model of continuing-care in which the same staff look after service-users in the hospital and at home. This service is considered a pioneering service because of its integrated nature and the service it provides.

The service is continually developing. The team are currently piloting a crisis service to target older people with depression, and they are also considering expanding to include early interventions.

### **Setting up the team**

#### *Initiation of the team*

The acute service manager and the consultant psychiatrist who currently lead the team conceived this crisis service. Both are hugely committed to the service. The new service is an exemplary model that combines both a new inpatient facility and home treatment under one roof. This arrangement makes this crisis service different to that of other CRTs. The model has received national interest from other Trusts who are keen to adopt a similar model.

Prior to the present crisis service there were two acute admission wards (one with 25 beds and the other with 10) and a home treatment team. There was, however, a desire to have an integrated team that would combine inpatient

and outpatient care, where the same staff looked after service users both when they were in hospital and after discharge. This was to ensure service users had good continuity of care throughout their crisis. At this time, the medical staff ran separate home and community services and, again, wished to integrate this service within a unified structure.

The present team lead had initiated the development of an integrated service by having several meetings with crisis staff to explore how the teams could be mixed.

#### *Time to plan the service*

The team had 15 months in which to prepare for the new service. The management at this stage knew what they wanted to achieve and sought to inform staff about how this could be set up.

#### *Working with stakeholders to develop the service*

Two ex-service users were employed as part of the team; one as a support worker and one as a patient advocate. Meetings were arranged to inform service users and carers of the changes and how these would be implemented. These groups were consulted and offered reassurance. Service users and carers were also invited to a workshop to help with deciding what the building for the team would look like.

There was initial conflict with the CMHT. Staff in the CMHT were accustomed to service users in a crisis being admitted to hospital for about three weeks and with the new integrated team being discharged much earlier. However, the key selling point was the beneficial effects for the service user as a result of the new care model which provided continuity at all times.

#### *Initial staffing of the team*

The staff for the team came from the existing home treatment team and the inpatient wards. In transforming to an integrated service and taking on both inpatient and community roles, the staff were expected to perform roles that they had not been originally employed to do. Staff expressed a lot of anxiety about carrying out roles they had not done before.

#### **Initial team development**

During the transition period, staff were asked to shadow the other staff who worked in different areas to them (either the ward or community). This was useful because it helped to develop a shared understanding of the different roles and also helped the two teams to become familiar with each other.

There were also regular staff meetings during the initial 15-month period where people's concerns and problems were discussed and solutions formulated.

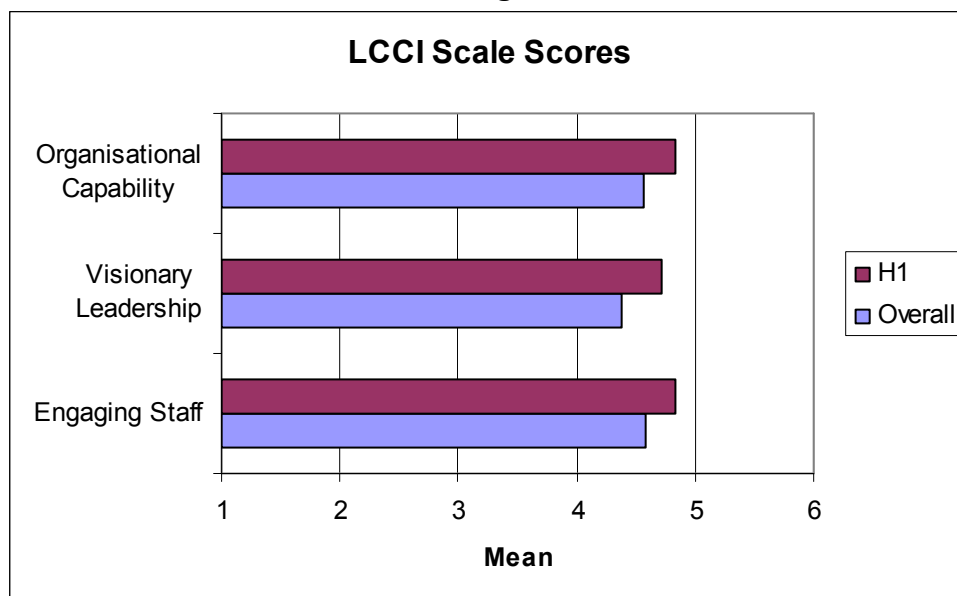
There was anxiety amongst the team at the beginning, but with time these anxieties have reduced, especially as the benefits to service users of the new way of working have become apparent.

## The Team

### *LCCI scales*

Figure H1.1 and Table H1.1 show the three LCCI scale scores for the H1 team. All scores are below a mean of 5, but still above the scores for the sample as a whole. The team lead was able to engage team members ( $m=4.84$ ,  $SD=0.87$ ) and considered capable of organising the team ( $m=4.83$ ,  $SD=0.70$ ). The effect size differences are relatively small but nevertheless exceed the overall LCCI scale scores.

**Figure H1.1**



**Table H1.1**

LCCI Scales							
	Overall			H1			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	18.00	4.84	0.87	<b>0.30</b>
Scale 2 - Visionary Leadership	727	4.38	0.89	18.00	4.72	0.74	<b>0.39</b>
Scale 3 - Organisational Capability	728	4.56	0.79	18.00	4.83	0.70	<b>0.34</b>

### *Team Vision*

The team broadly shared the same aims and goals: to avoid admission to hospital and treat people in the community. The crisis service was an integrated one where both the inpatient ward and the home treatment team were housed in the same building. In essence, in-patient care and community crisis care were all part of the same service, ensuring that care was coordinated throughout the service user's crisis. As such, a crucial aspect of the team's vision is a whole systems approach. Also central to the team's vision is its user-centred focus.



The team also appear to have a problem-solving philosophy to difficulties they encounter; instead of seeing problems as difficulties, they are regarded as challenges.

#### *Composition of the team*

The composition of the team is considerable. The total number of staff is 42 (40 full-time and 2 part-time). However, not all these staff are devoted to CRT. The team carries out a range of acute services to cover the full spectrum from inpatient care, home treatment and crisis resolution. The team itself includes senior practitioners, nurses, support workers (including a service user support worker), a social worker, an occupational therapist, medical staff, team managers, and administrators.

The team lead would have liked to have more staff, and more service users, but budget constraints would not allow this. He did recognise, however, that the team were well staffed in comparison to other CRTs.

#### *Multidisciplinary*

As can be seen from above, the multidisciplinary nature of the team is very good. The team contains not just the essential staff detailed in the MHPIG, but other staff such as an art therapist, a pharmacist and a technical instructor. There is also an acute service manager and a team leader. The latter manages the day-to-day activities of the team, but the acute care manager has overall lead. Potentially the team is able to provide a comprehensive range of interventions for people in crisis.

A significant asset to the team was a service user mental health support worker. This team member was not only clear about the team's goals but also added an important service user perspective into the team's practice. The service user described their role as "*advise[ing] everyone on how users would like to be treated...I develop best practice for user led services and stand up for users' need*".

#### *Team expertise and experience*

The expertise and experience within the crisis service is considerable. There are a number of senior practitioners who are highly experienced in working with people with mental health problems. The support staff also had a great deal of experience.

However, some of the team were being asked to take on roles that they were not familiar with and did not have experience in, but, as seen previously, the 15 month transition period was used to try and fill this gap.

#### *Full time dedicated psychiatrist*

Four medical personnel provide all the clinical input for this crisis service. The full time consultant psychiatrist leads on all the clinical activities and, together with the acute service manager, assists with managing the service. All clinical members of the team are full time, which is considered to be important in terms of assessment, medical concerns and medication issues. The medical

staff in the team are committed to the principles of crisis resolution care in the community.

#### *Team structure*

The team lead tried to have a team that is relatively flat in hierarchy as he wanted to have a team with no divisions. However, given the variety of different grades of staff in the team, it is inevitable that a level of hierarchy will exist. From observations, the hierarchy in the team was apparent, but it appeared to work well.

There seems to be an unusual hierarchy with regards to the leadership in the team. The team lead did not have a great deal of control over how the team was led with regards to strategy and service development, this, instead, was done jointly by the acute service manager (a nurse by background) and the consultant psychiatrist. The team lead's leadership was restricted to the team's activities on a day to day basis.

#### *Relationships within the team*

A great strength of the team was that all staff communicate well with each other. This was commented on by at least two of the interviewed staff. The team lead described one weakness where there was still a minority of staff who wanted to stay true to their discipline, for example, ward staff who were reluctant to do community work and community staff who preferred not to work on the ward. Occasionally, this created a 'them and us' situation, but this has diminished over time. There was an underlying sense, predominantly from senior staff, that working in this integrated way was the only real way of providing a comprehensive crisis service.

Staff were described as very friendly and supportive. One nurse explained how '*we care for each other*' and if staff were 'worn out' other staff were willing to cover their shift if necessary. At times the team was overstretched if some staff were on leave or off due to sickness. But this appeared to be only one of a few difficulties experienced by the team on carrying out their day to day duties.

#### *Team development*

As seen above, the team have regular forums to communicate as a team. The team lead uses meetings to discuss issues arising and uses these to solve problems collectively.

#### *Staff morale*

After the initial introduction of the newly formed service there were a few team members who were unhappy with the changes and left. This was not perceived by the team lead as a bad thing. As he explained, "*sometimes attrition is a healthy thing.*"

In this case, the turnover of staff resulted, for the most part, in those who were highly motivated and very committed to what they do. The team are

committed and motivated to achieve the team's vision and staff morale was considered to be very good.

### **Relationships with external agencies**

The team reviewed on a daily basis the range of options or combinations of options available for service users and carers, whether home treatment, a crisis bed, inpatient care, or a psychiatric intensive care unit and so forth. Links with external agencies were quite extensive. Regular meetings were held with other teams like the CMHT, assertive outreach and dual diagnosis. These joint meetings were considered important for encouraging good relations with external agencies, and kept everyone informed.

Occasionally relationships with external agencies were strained and communication difficult. Very often physically going to the team and talking to staff resolved these tensions.

There were good working relationships with the local A&E department as one of the team members was an A&E liaison nurse. Active involvement of the GP was considered important given GPs are often a service user's first port of call in a crisis. There were problems with involving GPs at first. Often the GP would try to avoid any meetings, but the team would persevere and make a visit to the surgery.

#### *Difficulties with multi-agency working*

Difficulties with multi-agency working appeared to be few and far between. The team pursued activities that contributed to maintaining good relationships with external agencies, which the team benefited from.

#### *Approach to building good relationships with external agencies*

These have already been described above. Essentially the team would arrange regular meetings with various external services to discuss cases or simply maintain good relations with them. The team was generally well received by external agencies who were grateful for their help. Good communication between agencies was the key.

The team lead consulted extensively with external stakeholders when the service was being developed, which was very good groundwork for subsequent relationships.

### **Focus on leadership**

The team members interviewed described several types of leadership. These included:

#### *Supportive leadership*

The most commonly described leadership attribute was being supportive. The team leader, for example, commented on how he had a great deal of support to do the work he did. Difficulties or concerns were discussed openly in the team and members felt very supported. Being approachable, flexible and

listening to co-workers was important to resolving tensions and ensuring supervision took place - both clinical and managerial.

#### *Autocratic vs. democratic leadership*

One of the interviewees described the service manager as a bit controlling whenever there was a crisis, taking charge and managing staff. Also, there was a perception that sometimes there was a lack of information.

However, there are forums for discussion within the team and for people to be able to state their opinion and to have this considered. There does seem to be a joint problem-solving ethos.

#### *Visionary leadership*

This was a vision described by the acute service manager. Leadership was perceived as someone who had vision to see how the team could make further developments, continually review how care for the client group can be improved and improve their quality of life. It was also considered important to be caring and passionate towards staff, be mindful of their career ambitions and promote staff where possible, as a way of maintaining their job satisfaction and motivation.

From what has been discussed, it is clear that the leadership in the team is visionary.

#### *Practical leadership*

Interestingly for the consultant psychiatrist who led all clinical activities of the team, leadership was described as not being about a system or model, but more of a practical thing. Open access was key, where staff could approach the consultant when needed.

### **Outcome measures**

#### *Hospital Admissions data*

Table H1.2 lists the number of referrals, assessments and admissions for H1. This integrated crisis service resulted in higher admissions to hospitals compared to other teams examined in the study. The average percentage of admissions in relation to the number of assessments performed was 41%. The percentage of admissions by numbers of referrals to the team was 28%. Stay in hospital, however, appeared to be short and early discharge emphasised. We were unable to record bed occupancy rates for participating teams, but the team itself monitored this noting a 40% reduction since the team's inception in July 2005.

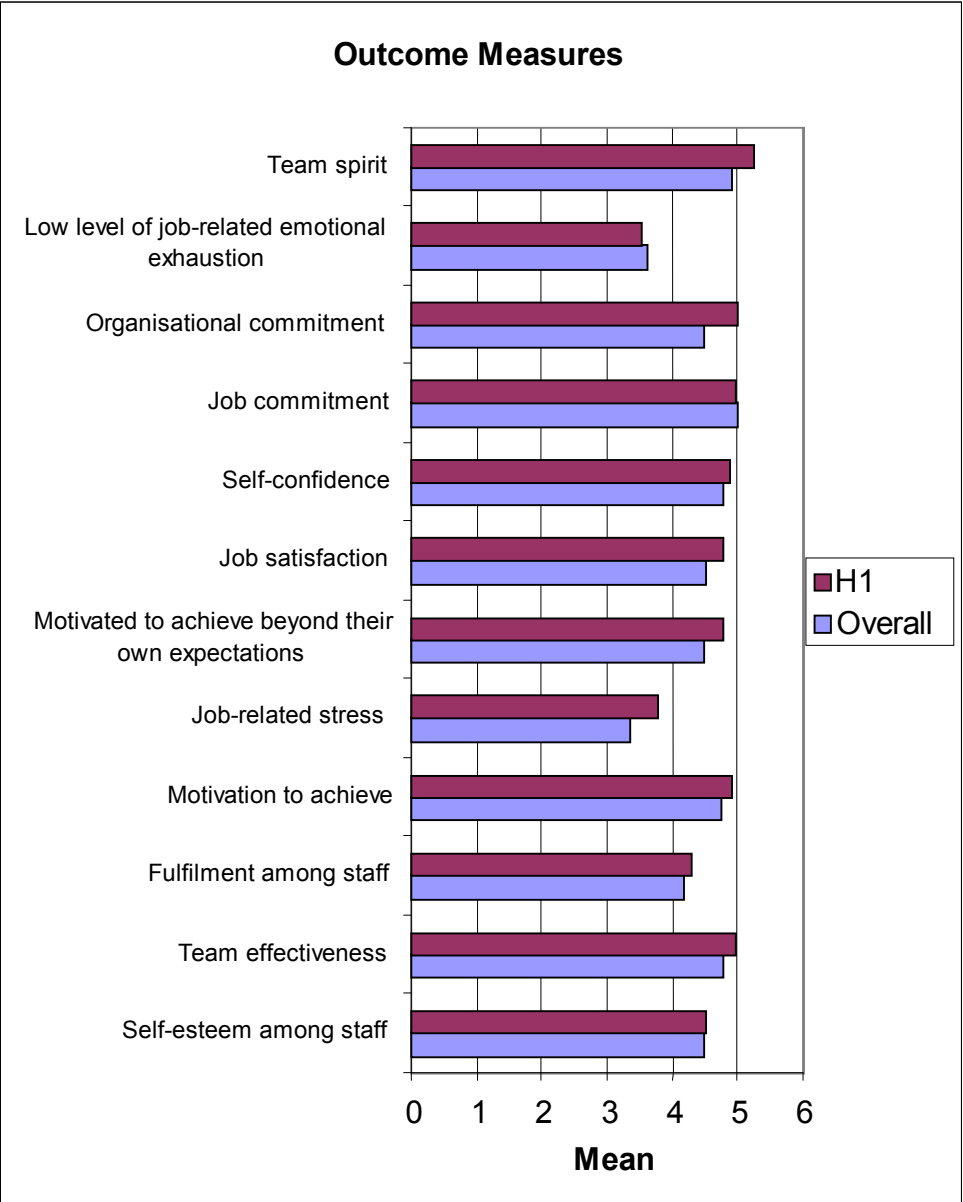
**Table H1.2**

	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Sep-05</b>		33	28
<b>Oct-05</b>		43	17
<b>Nov-05</b>		36	18
<b>Dec-05</b>	48	43	12
<b>Jan-06</b>	61	50	20
<b>Feb-06</b>	64	49	11
<b>Mar-06</b>	60	45	18
<b>Apr-06</b>	56	49	18
<b>May-06</b>	64	51	13
<b>Jun-06</b>	52	42	20
<b>Jul-06</b>	57	42	18
<b>Aug-06</b>	56	41	17

**Outcome measures**

LCCI results on outcomes for the team are shown graphically in Figure H1.2 and in detail in Table H1.3 below. The team is particularly strong in terms of team spirit with a mean outcome score above 5 which is very high ( $m=5.22$ ,  $SD=0.88$ ). Commitment to the organisation commitment is also high ( $m=5.00$ ,  $SD=1.08$ ). Team effectiveness ( $m=4.94$ ,  $SD=0.87$ ) and job commitment ( $m=4.94$ ,  $SD=1.21$ ) are again relatively strong. However, there were lower outcome scores for low level of job-related emotional exhaustion ( $m=3.53$ ,  $SD=1.50$ ) and job-related stress ( $m=3.78$ ,  $SD=1.44$ ). Effect size differences for most outcomes exceeded the means for the overall sample, except for job commitment and low level of job-related emotional exhaustion.

Figure H1.2



**Table H1.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>H1</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	18.00	4.50	1.15	<b>0.03</b>
Team effectiveness	725	4.78	1.12	18.00	4.94	0.87	<b>0.15</b>
Fulfilment among staff	717	4.17	1.26	18.00	4.28	1.27	<b>0.09</b>
Motivation to achieve	720	4.73	1.03	18.00	4.89	1.02	<b>0.15</b>
Job-related stress	712	3.35	1.47	18.00	3.78	1.44	<b>0.29</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	18.00	4.78	1.06	<b>0.27</b>
Job satisfaction	712	4.51	1.23	18.00	4.78	1.22	<b>0.22</b>
Self-confidence	714	4.78	1.02	17.00	4.88	1.17	<b>0.10</b>
Job commitment	718	4.98	0.93	18.00	4.94	1.21	<b>-0.04</b>
Organisational commitment	719	4.46	1.07	18.00	5.00	1.08	<b>0.51</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	17.00	3.53	1.50	<b>-0.06</b>
Team spirit	720	4.89	1.20	18.00	5.22	0.88	<b>0.28</b>

## **Conclusion**

Despite relatively high admissions to hospital this integrated team appeared to function very well. Leadership by both the acute service manager and the consultant psychiatrist appeared effective. Team members expressed feeling well supported and clear about the aims and goals of the service they provided.

It is unclear why, given the integrated approach the team has to providing care, the hospital admission rates are relatively high. One reason could be the flexibility afforded to the team in terms of how they manage people's care due to their integrated approach. Because of this flexibility, the team may not be reluctant to admit to hospital in the first instance as they have full control over when the person is discharged, making early discharge, if appropriate, relatively easy. This flexibility is not too dissimilar to other teams having access to crisis beds; it is just that crisis beds are not included in hospital admission statistics.

Another possible reason for the relatively high hospital admission statistics could be that, because of the shared culture between inpatient and community care, the team might not to be as reluctant to admit to hospital as other teams where there is a strong medical culture in inpatient care. As such, the care delivered in hospital for H1 is consistent with the philosophy of crisis resolution care, whereas, for some teams, the care provided in hospital is dominated by the medical model.

## Case Study H2: High admissions team

Eleven out of 14 members of the team completed the LCCI at baseline, making the response rate for the team 79%. Seven members of the crisis service were interviewed as part of this case study.

### **Context**

#### *Background*

Team H2 is based on the outskirts of London. The team covers a catchment area with higher than average rates of psychiatric morbidity, indicated by a MINI score of 1.24. Mental health services in the borough are amongst the most poorly resourced in London. The team has fifteen full-time staff and three part-time. The composition of the team includes a team lead, six nurses, five social workers, three support workers, an associate psychiatrist and two administrators.

This CRT was created in 2004. The team serves a population of approximately 200,000. The average caseload size at any one time is 25. There is no limit on how long service users are seen by the team. The proportion of service users seen with a severe mental illness was unknown, as the team did not usually collect this data.

The team has a gate-keeping role for all admissions to hospital. It runs a 24 hour service, 365 days a year. Staff shift hours are from 8am to 4pm, and 2pm to 10pm, with 10pm to 8am being covered by an on-call system.

### **Setting up the team**

When setting up the team the main difficulties included finding suitable accommodation. Staff recruitment also proved difficult and once the team began, operating problems with the interface with the CMHT and inpatient units became challenging.

### **The Team**

#### *LCCI Scales*

Figure H2.1 and Table H2.1 present the results of the three LCCI scale scores for H1. Scores were fairly positive, with all three scores above a mean of 4. Staff were engaged in the Team's activities ( $m=4.53$ ,  $SD=0.80$ ) and perceived the team lead to be able to organise these activities relatively well ( $m=4.47$ ,  $SD=0.81$ ). Table H2.1 provides further details of the results for the LCCI scores. Each score is marginally lower than that of the overall sample, as revealed by the effect size differences.



Figure H2.1

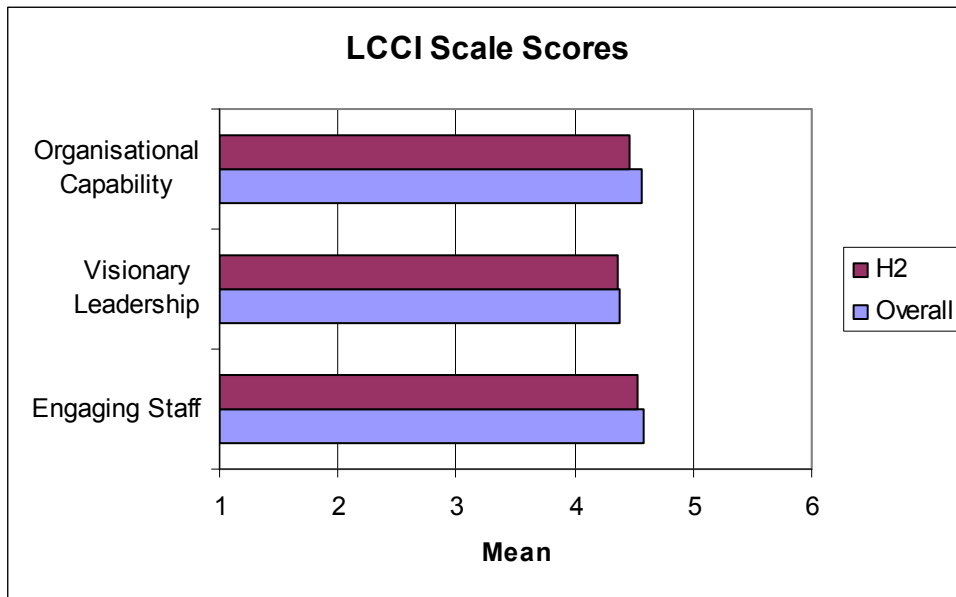


Table H2.1

LCCI Scales							
	Overall			H2			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	11	4.53	0.80	-0.06
Scale 2 - Visionary Leadership	727	4.38	0.89	11	4.36	0.90	-0.03
Scale 3 - Organisational Capability	728	4.56	0.79	11	4.47	0.81	-0.12

*Team Vision*

The team members interviewed were very clear about their specific roles and the main objectives of the team. Staff shared the same vision of caring for service users in their own home, when in crisis, and were focused on this. They also provided support for families, particularly in helping them understand the person’s illness. For staff it was more than just a job. The goals of the team were sustained through meetings explaining the criteria in the protocol and the guidelines staff were required to work towards.

**Composition of the team**

*Multidisciplinary*

The team was reasonably multidisciplinary, including RMNs, ASWs, support workers, and medical staff. The team also has access to a pharmacist once a week. However, it lacked an occupational therapist and a clinical psychologist.

The team work within a social systems model and the lack of an OT or clinical psychologist hampered efforts to working more effectively with this approach.

For example, if a person in crisis was very anxious about leaving their home, an OT would have been ideal to assist with this.

### *Staffing levels*

Staffing levels were also an issue. The team lead was well aware of these difficulties and the consequences of them. As she put it '*we struggle with staffing levels and because we are a small team we loose flexibility*'. It meant existing staff put under a lot of pressure, which the team lead was conscious of. The situation became even more intense during staff sickness, which made it even harder for the team to function. On one occasion the situation became particularly intense the team lead had to resort to shutting down the unit for six days (inclusive of weekends). The biggest impediment to recruiting more staff was funding, although there were plans to increase the size of the team.

### **Full time dedicated psychiatrist**

The team had a full time associate psychiatrist who was well regarded by the other team members. Their role was to lead on all medical issues and provide advice to the team on mental health act assessments, medication and physical health problems. Physical contact appeared limited, however, because of the shift system. Communication between the psychiatrist and other team members was mostly via emails and memos. The team has access to a consultant psychiatrist once a week for half a day.

One issue was the need for a junior doctor to work with the associate psychiatrist who could see service users at the CRT as well as the inpatient ward.

### *Team expertise and experience*

Team members had relevant expertise and were experienced staff, including senior nurse practitioners. The team lead was an experienced manager and was undertaking a post-graduate degree in management to build on this.

### *Team structure*

Each team member saw the value of each other's role and expertise and none regarded themselves as more superior than the other. There was no medical dominance in the team. The psychiatrist only took the lead on medical issues and felt it important to allow, for example, social workers take the lead where social issues were concerned.

### *Relationships within the team*

Relationships within the team were said to be very good. Differences of opinion were settled through healthy discussions and reaching a joint decision. Business meetings, held fortnightly, were used to discuss a range of issues, such as covering shifts. The team had been giving each other support to deal with the high levels of stress staff were often under with the pressures of their work. External consultants or a psychologist would be invited to provide therapy or talk to the team. The team lead felt this was especially

important given the levels of stress amongst staff. This was noted in the LCCI outcome measures detailed below.

### **Team development**

The team had been given training to apply a social system model. Risk was a key issue for the team and an area in which regular refresher training was required. The team were aware of how their threshold for risk was higher than that of other community teams.

The team do have group clinical supervision, which is important from a risk management perspective. However, the team lead noticed how some staff felt uncomfortable about talking in a group. During weekly group supervision certain staff would take the day off and so would not receive this. An external consultant was brought in to help facilitate discussions within the team, which helped a great deal and led to some improvement in the way the team functioned.

Apart from clinical supervision, the team also have regular meetings to discuss protocols, guidelines, and business issues. Apart from the difficulties mentioned above, the team lead and the other interviewees felt that staff felt able to communicate openly at team meetings and during supervision, and were able to express concerns and problems.

CRT staff thought it would be useful to have 'away days' or team building exercises together with the CMHT.

### *Continuing professional development*

The team lead attended conferences as part of her further training and, as described, attended a postgraduate course in leadership management. She felt this was of enormous benefit to her role. Other team members stated how they could have training or attend conferences if they wished. The team had a system of individual clinical supervision in place.

### *Team morale*

The team leader described the team as very committed, and because of that fewer problems arose within the team.

### **Relationships with external agencies**

The team had changed accommodation to be geographically closer to the CMHT. It was thought this would enhance working relationships between the two teams. To some extent this was did happen, but other difficulties soon became apparent. The team found the CMHT tended to '*dump a lot of work on us*'. As the social worker explained, '*our efficiency depends on them at times*'. The team were flexible in what they would accommodate but, in view of staff shortages, found this increasingly difficult to take on. Relationships with the CMHT are better than they were.

The team lead has a good relationship with the CMHT manager. Each understands the pressures they have to endure, and communication between the teams is much better.

In order to illustrate this point further, an observation was made during the course of conducting the case study for this team. On a Friday just after 5 pm, a member of the CMHT came directly to the CRT to ask staff to take on referrals because, not only were they were anxious about the particular cases, but also because they wanted to go home. This type of 'dumping' created significant problems for the CRT's workload.

The team's relationships with the Assertive Outreach Team (AOT) are strained at times. Given the AOT work intensively with service users, they often feel they ought to be able to admit them to hospital. The AOT do not work 24/7 anymore, but used to have the same availability as the CRT. Their hours of work have reduced; because of this the CRT has to take on these clients out of hours and therefore insisted they keep the gate-keeping role.

#### *Relationship with the PCT*

During the first year of operation the CRT would receive complaints from the PCT for not having enough people on their caseload. Initially the team had between 14-15 people and it should have been 25. In 2005 the team had a caseload of 52 people at any one time. The team lead considered this 'dangerous' and, despite putting in place additional staff, there was only one doctor. Staff became very unwell from having to work an extra shift. Since this the team lead has not allowed the caseload to exceed 25.

#### *Difficulties with multi-agency working*

Perhaps the biggest area of contention with the CMHT concerned methods of referral, which has been outlined above. Somehow the CMHT perceive the CRT as a 'safety net', in which clients they are concerned about, but not necessarily in a crisis, are referred to the team for out-of-hours care. This served to blur the role boundaries of the CRT and extend its role beyond what it should be doing according the MHPIG.

#### *Pressures to perform*

Gate-keeping sometimes added to the already intense pressures the CRT was under. Team members would attend delayed discharge meetings held on the ward and liaise closely with the ward, but there were certain issues the team had no control of. Early discharge from the ward was often difficult because of accommodation problems. Bed occupancy days had been reduced by 19%, which the team lead recognised as not especially good compared to other teams. She added, however, that this was partly due to closing 5 beds, which happened for funding reasons and not because the CRT was introduced. The team lead maintains that had these beds remained open their impact on bed occupancy days would be been greater.

Tensions with the ward consultant psychiatrist can sometimes impede the team's gate-keeping activities. The team lead would usually attend a meeting with the consultant and the CMHT to iron out any difficulties.

#### *Balancing safety and risk*

Balancing safety and risk was a key feature of the team's day-to-day work. The team lead provided an interesting account of how different professionals viewed a person's risk. She described how the threshold of risk was much higher for experienced nurses in the team relative to newer people or social workers whose threshold was much lower. Risk of harming themselves or others was usually the main deciding factor as to whether to admit the person or not.

#### *Approach to building good relationships with external agencies*

The team lead favoured physical contact with external agencies. This appeared to work best, particularly when resolving particular difficulties.

#### *Cramped accommodation*

Despite the move to newer accommodation it was evident the team was short of space. A few of the staff did not have their own workstation and would have to share with each others. All members of the team worked in an open plan office, including the team lead. In some ways this aids good communication between members but the shortage of space resulted in staff not being particularly happy about the arrangement.

### **Focus on leadership**

All team members interviewed had fairly clear ideas of what good leadership entailed.

#### *Democratic leadership*

As one social worker put it, '*leadership can change from one person to another. At every shift there is a leader*'. This democratic leadership approach was something other team members also described. This concurred with what a support worker described and mentioned how, even though she was on a lower grade, she would still have some form of leadership role within the team and that this was shared equally among all members.

#### *'Hands on' leadership*

Practical or 'hands on' leadership was a crucial theme for the team lead. In view of the staff shortages experienced by the team such a hands on approach was essential. Working in a flexible manner and leading by example is what the team lead felt was important for the staff she managed. The associate psychiatrist mirrored this view. For her, a good leader was also someone who was a good worker. Part of being hands-on sent a positive message to staff, who felt the lead could be relied on at any time and be encouraging.

### *Problem solving leadership*

Being able to sort out problems was seen as an important attribute in a good leader. One senior nurse practitioner described someone who is able to discuss issues and problems easily and then solve them.

### *Supportive leadership*

This was again a common form of leadership. Encouraging and supporting staff was considered crucial for their well-being and effective working.

## **Outcome measures**

### *Hospital Admissions data*

Admissions to hospital for H2 are detailed in Table H2.2. These are moderately low rates and, at the time they were collected, represented the fourth lowest of the entire 'bottom' performing teams examined. The average proportion of admissions in terms of numbers of people assessed was 23%. In terms of those referred to the service, the average proportion of people admitted was 19%.

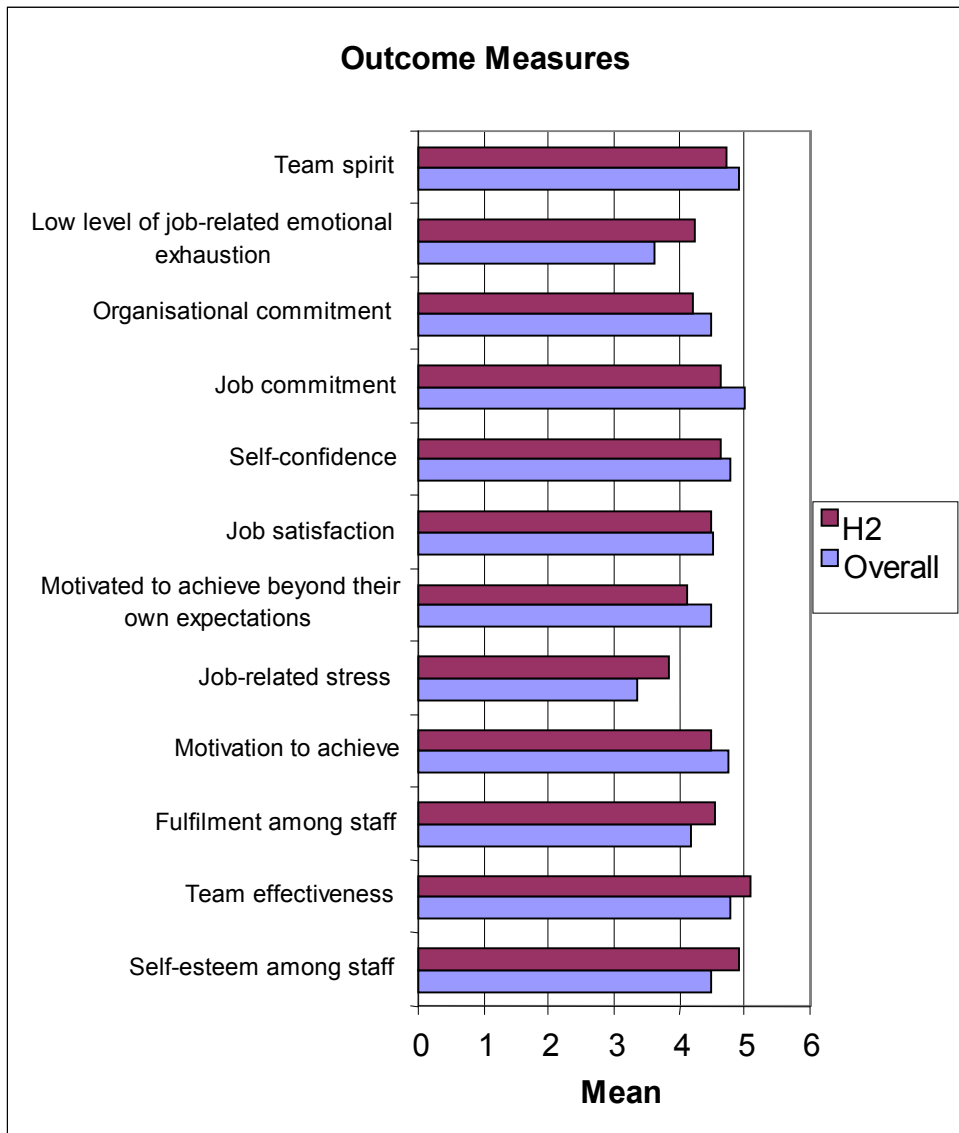
**Table H2.2**

	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Apr-05</b>	65	48	10
<b>May-05</b>	51	50	6
<b>Jun-05</b>	63	47	13
<b>Jul-05</b>	61	49	14
<b>Aug-05</b>	76	58	10
<b>Sep-05</b>	52	41	11
<b>Oct-05</b>	56	42	13
<b>Nov-05</b>	66	53	12
<b>Dec-05</b>	63	46	12
<b>Jan-06</b>	72	59	15
<b>Feb-06</b>	63	65	12
<b>Mar-06</b>	74	64	16

## **Outcome measures**

Figure H2.2 and Table H2.3 list the outcome scores for Team H2. High outcome scores were found for team effectiveness ( $m=5.09$ ,  $SD=0.94$ ) and self-esteem among staff ( $m=4.91$ ,  $SD=0.70$ ). Team spirit was also high ( $m=4.73$ ,  $SD=1.10$ ). Staff were confident ( $m=4.64$ ,  $SD=1.12$ ) and committed to their jobs ( $m=4.64$ ,  $SD=1.03$ ). The lowest outcome score was for job-related stress ( $m=3.82$ ,  $SD=0.98$ ) and reflected staff's own accounts in the interviews carried out; however, this was a more positive score than the overall sample. Seven of the twelve outcome scores examined fell below the scores for the sample overall (see effect size differences in Table H2.3).

Figure H2.2



**Table H2.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>H2</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	11	4.91	0.70	<b>0.36</b>
Team effectiveness	725	4.78	1.12	11	5.09	0.94	<b>0.28</b>
Fulfilment among staff	717	4.17	1.26	11	4.55	1.29	<b>0.30</b>
Motivation to achieve	720	4.73	1.03	11	4.45	0.93	<b>-0.27</b>
Job-related stress	712	3.35	1.47	11	3.82	0.98	<b>0.32</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	10	4.10	1.20	<b>-0.34</b>
Job satisfaction	712	4.51	1.23	11	4.45	1.13	<b>-0.04</b>
Self-confidence	714	4.78	1.02	11	4.64	1.12	<b>-0.14</b>
Job commitment	718	4.98	0.93	11	4.64	1.03	<b>-0.37</b>
Organisational commitment	719	4.46	1.07	11	4.18	1.08	<b>-0.26</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	9	4.22	0.97	<b>0.42</b>
Team spirit	720	4.89	1.20	11	4.73	1.10	<b>-0.13</b>

### **Conclusion**

Team H2 appeared to manage many of its difficulties relatively well considering the pressures it encountered. Staff shortages acted predominantly as a barrier towards more effective working. Despite this team effectiveness was perceived as very good. Staff were committed and had high self esteem. Stress among staff was perceived to be problem by the team.



## Case Study H3: High admissions team

Thirty-four out of 39 members of staff completed the LCCI at baseline, making the response rate for the team 87%. Eight members of the team were interviewed.

### **Context**

#### *Background*

Team H3 is a CRT based in a mixed urban/rural area. The MINI score for the area is 1.01, indicating average mental health needs in the area. There are thirty full-time staff and six part-time staff in the team, of which there are: 20 RMNs, 2 full-time psychiatrists, 2 social workers, 2 occupational therapists, 5 support workers, and 2 clerical staff. The team had been in existence since April 2004.

The team serves a population of approximately 620,000. The average caseload is 30 service-users at any one time and there is no declared limit on how many service users the team can see. The team try and limit their involvement with service-users to 2-3 weeks. The average proportion of service users with psychosis is thirty percent.

The initial plan for the team was to set up two crisis teams in the area; however, due to resources they decided to have one team covering the whole area. This means that the team covers a very large geographical area (approximately 600 square miles). This creates real difficulties for the team members, as they spend a great deal of their time travelling, as opposed to delivering care.

In the first year the team initially started they were operating mainly as an assessment team. A&E was the main source of their referrals and, as such, they spent the majority of their time assessing people in A&E. As this was very different from home treatment, it posed difficulties for the CRT staff who were meant to be providing home-based treatment but were, in reality, acting as A&E liaison workers.

To try and overcome these difficulties, a separate A&E team was set-up in March 2005. This team worked from 8am until midnight, leaving the CRT to operate as a home-based crisis treatment team during this period.

The team is partially gate-keeping and provides 24hr care, 365 days of the year. The out-of-hours service is covered by shifts, as opposed to an on-call system.

Since the team has been in existence there has been no change in team lead.

## **Setting up the team**

### *Initiation of the team*

Prior to the introduction of the crisis team there was no community based crisis resolution work in the district. There was a mental illness support team that provided out-of-hours low-level support (primarily telephone contact). This was closed and the resources were redirected into the CRT.

### *Time to plan the service*

A project group was set up in 2002 to develop the CRT and the team became operational in April 2004; therefore, there was approximately two years to plan the service.

### *Working with stakeholders to develop the service*

A project group was set up to develop the service, which included representatives from carers, service users, and service commissioners. The aim was to incorporate the views of the DH with the ideas of the stakeholders to determine the target population, budgetary requirements, hours of service, team composition, and mechanisms for evaluation. The outcome of this planning phase was an in-depth operational policy.

### *Initial staffing of the team*

All the staff were recruited externally to the team.

### *Initial team development*

A four-week training programme was arranged prior to the service becoming operational. SCHM provided eight days training on the key elements of working as a CRT.

## **The Team**

### *LCCI scales*

The results for the three main LCCI scales are presented graphically in Figure H3.1. The detailed results are presented in Table H3.1. It can be seen from this that the scores are very similar to the overall sample. Considering that the scales range from 1-6, with the mean for each scale being approximately 4.5, the team's scores show reasonably positive perceptions of the leadership in the team.

Figure H3.1

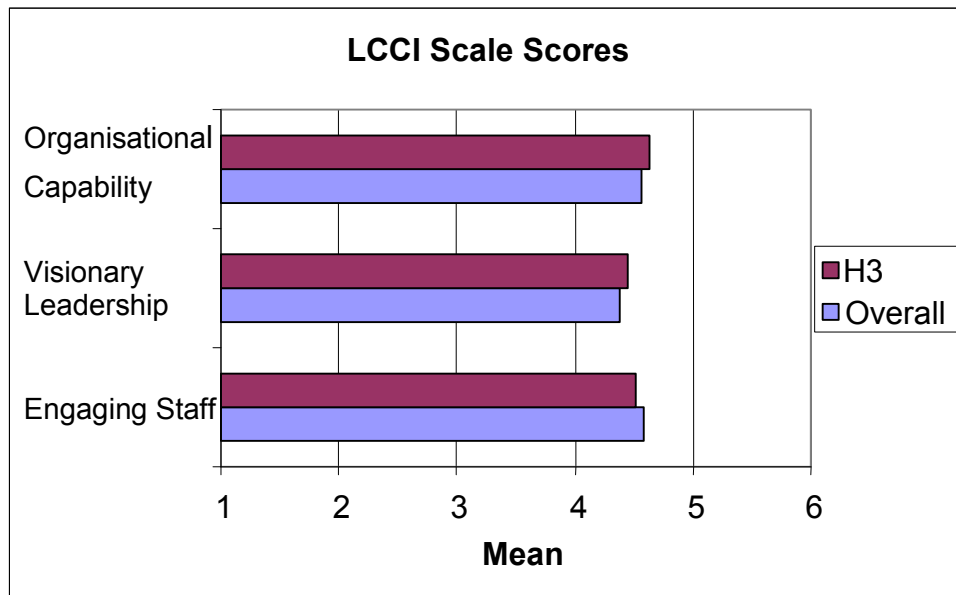


Table H3.1

LCCI Scales							
	Overall			H3			Effect size differences
	N	M	SD	N	M	SD	
Scale 1 - Engaging Staff	726	4.59	0.86	34	4.52	0.79	<b>-0.08</b>
Scale 2 - Visionary Leadership	727	4.38	0.89	34	4.44	0.65	<b>0.07</b>
Scale 3 - Organisational Capability	728	4.56	0.79	34	4.63	0.65	<b>0.08</b>

*Team Vision*

There is a clear vision in the team that is shared by all team members. This vision is centred on providing good quality care for people in their homes. The approach is user centred, and incorporates the social and relationship aspects of the service user, not just the medical aspects.

There seems to be quite a structured approach to ensure that the philosophy of the team is realized. There is a clear operational policy focusing on achieving home-based care and this is adhered to. In this sense, team H3 appears to be different to some of the other teams with regards to the degree of flexibility they offer in the service they provide.

The Senior Management Team (SMT) also discussed and formulated a plan of how to ensure the aims and goals of the team are achieved.

In terms of how the aims and goals are permeated throughout the team, there are multiple communication forums in which this is done. These include twice daily clinical handover meetings, weekly group clinical supervision meetings, individual clinical supervision, monthly business meetings, and occasional away-days.

There is a strong sense of commitment to the aims of home-based treatment. This commitment is assisted by the team lead's "passion" and focus on the aims of the team; according to one of the team members, she always keeps the goal in mind and makes people work towards it.

### **Composition of the team**

With thirty full-time staff and six part-time staff, team H3 is a very large team. This is not surprising given the large size of the catchment area. There were communication problems associated with such a large team, given the difficulty of having a meeting with all team members present.

#### *Multidisciplinary*

As described above, the team contains social workers, nurses, support workers, occupational therapists, and clerical staff; therefore, it is multidisciplinary in nature. However, the team is "very top-heavy with nurses", and there is a desire from the team lead and one of the consultants to have more OTs and social workers.

#### *Team experience*

The team lead recruited people with high levels of experience so they can work autonomously. She is pleased with the quality of staff within the team.

#### *Psychiatric input*

The team has two full-time consultant psychiatrists. They advise on whether or not a person should be admitted into hospital, educate staff on clinical problems, and also form part of the senior management team. The medical staff are committed to the crisis model.

The team lead feels that her relationship with the consultants is very good, which helps in service delivery.

#### *Team structure*

Team H3 has a senior management team consisting of the team lead, a senior practitioner and the two consultant psychiatrists. Having a senior management team seems more hierarchical than some of the other case study teams. The senior management team meet to discuss and plan service delivery. They then arrange meetings to communicate what has been discussed to the other members of the team.

The presence of a senior management team does not mean that the team management are autocratic. According to the team lead, relevant issues will be discussed with the rest of the team and the team lead encourages people to air their views and openly discuss any problems they may have.

The team also has a shift coordinator for each shift; this person is always a senior practitioner. One of the lower grade practitioners felt that this was a "bone of contention" within the team, as other people would like the opportunity to take on this role.

### *Relationships within the team*

All the interviewees felt that, on the whole, relationships are good within the team; team members experience friendship and support from their colleagues.

It is acknowledged that at times there will be conflict between team members. If the team lead perceives there to be a persistent problem between certain colleagues she will address this with the relevant people and try to find a solution.

There does seem to be friction between the senior management team and the rest of the team, evident from the following comment made by one of interviewees: *“the team works work well together, the problem is with senior management”*. This comment suggests a “them and us” situation existing between senior management and the rest of the team; it is not clear from the interviews how representative this comment is.

### *Team development*

As previously mentioned, the team had an initial four week induction period. Since then there are multiple forums for the team to meet and reflect, including twice daily clinical handover meetings, weekly group clinical supervision meetings, individual clinical supervision, monthly business meetings, and occasional away-days. During these forums, the team are not afraid to challenge and question what is being said; they are keen to learn and work in a way that is consistent with best practice. As with the other teams, the multiple communication forums are regarded as useful in discussing caseload, having a sense of a shared caseload, and, ultimately, assisting in the management of risk.

Again, the size of the team makes it difficult for the team to develop as a cohesive unit, as it is not possible for them to all meet at any one time.

### *Continuing professional development*

With regards to individual development, all team members have clinical supervision, which they find useful. Some of the interviewees commented on the support and knowledge they received from their colleagues as a way of developing professionally. The team lead consciously tries to give people responsibilities that will lead to their career development.

These multiple forums for development are evidence of a continual learning culture within the team.

### *Staff Morale*

The team appear committed and motivated to the work they do. However, there was definitely a sense from a couple of the junior practitioners that there is a problem with team morale; for example, one person said “I am sure some people are not happy in the team”. There was some reluctance from these interviewees to expand on this, so the extent of the problem is not clear. It could be that with the size of the team it is inevitable that there will be some form of discontent.

## **Relationships with external agencies**

As with the other case study teams, relationships with external agencies, in particular CMHTs, have been problematic. To a certain extent, these problems are exacerbated for the team as, due to their large catchment area, there are many external agencies that work in the area. When the CRT initially started, the CMHTs felt threatened as they did not fully understand the role of the CRT. Since then, problems have been centred around CRTs, *“expecting them to do everything”*, owing to the lack of resources available to the CMHTs.

Team H3 have, and continue to do so, put a great deal of effort into trying to work effectively with the CMHTs; the result is that the relationships are now generally positive. Initially they visited the teams to explain their role and to *“try and build bridges”*. They have also successfully encouraged CMHT staff to come and visit them.

There are now structures in place to try and ensure good relationships with external agencies. As with the other teams, one of these structures is the existence of/and attendance at joint meetings. However, there are other structures present for H3 not present in the case study teams. One of these structures is a link worker who *“keeps things working well with the CMHTs”*. Also, as an attempt to maintain an integrated approach to the delivery of care, and to improve communication between the teams, H3 do joint assessments with the CMHTS; these are considered to be successful.

## **Focus on Leadership**

### *Inspiring and visionary*

As has been discussed, the team lead has a clear vision of user-centred crisis home treatment. This vision is central to the planning of the service and service delivery. The rest of the team share this vision.

### *Commitment*

It is clear from what has been discussed that the team lead is extremely committed to her work; the team lead acknowledged that she may be overcommitted and that she *“does too much and tends to overdo things”*.

### *Respect from the team*

Most of the people interviewed had respect for the team lead, saying that she was good at leading the team. However, there were a couple of comments by two interviewees that suggested not everyone shares the same opinion. For example, one of the interviewees said: *“I have always had problems – I can’t say anything more”*. Another of the interviews said when asked about the leader: *“not all the team is happy all the time, but she is good”*.

### *Team focus*

The team lead obviously values the team as a unit, as the existence of multiple forums to develop the team demonstrate. However, there is a sense

of fragmentation in the team that is created by the existence of the senior management team; a “them and us” situation.

#### *Fair*

The team lead feels that she is objective and fair to all staff; she will encourage all staff to express their opinions and will treat these with objectivity and respect. It was, however, insinuated by one of the interviewees that the team lead had “*favourites*”; as this was only one of the interviewees, the extent to which this is a problem is not clear. In response to this comment (which was in a joint interview), another of the interviewees explained that the size of the team makes it difficult to be fair to everyone.

#### *Hierarchical*

The presence of the senior management team and also the shift coordinator having to be a ‘G’ grade demonstrates that there is a hierarchy within the team. This hierarchy is purposeful, as the team lead believes that everyone should have specific roles and responsibilities.

The extent to which there is a ‘top-down’ approach to management within the team is not clear. There is definitely a sense that some decisions are made at senior management level and then communicated to the rest of the team. However, the team lead also discusses decisions with the team and will take on board their views. One of the strengths that a few of the interviewees listed about the team lead was her ability to make a decision when a consensus was proving difficult to achieve; demonstrating that the team are consulted with.

With a hierarchical structure, it can sometimes be the case that people are not given the chance to develop as much as they would like. The dissatisfaction with the shift-coordinator having to be a senior grade suggests that, to some extent, this may be the case. However, the team lead and one of the other interviewees believed that people are encouraged to take on responsibilities so that they are “*empowered to spark their ability*”.

#### *Hands-on approach to management*

The team lead describes herself as having a ‘hands-on’ approach to management; she will take a clinical lead and deliberately makes sure she is visible. Whilst this was admired by most of the interviewees, a couple of the team implied that the team lead had a tendency to micro-manage team members. Micro-managing professionals can be problematic, as generally they are autonomous practitioners.

#### *Supportive*

The majority of the interviewees commented on how supportive the team lead is. She is approachable and will help out with problems people are experiencing.

#### *Knowledge and skills to manage and develop the service effectively*

There was definitely a strong sense from the interviews that the team lead had the management skills and experience to ensure the effective running of the

service. She is very organised and ensures that there are consistent and clear systems in place for service delivery. There is a comprehensive operational policy that is adhered to and everyone in the team has clear roles and responsibilities within this. This clarity of operations and the consistency associated with this ensures that people internal and external to the team are aware of the boundaries they work within.

## Outcomes Measures

### *Hospital Admissions Data*

Admissions to hospital for H3 are detailed in Table H3.2. These are very high rates and represent the highest hospital admission rates for the whole sample. Further analysis of these data show that 91% of people referred and assessed by the team were admitted into hospital. This is obviously a very high figure, and was the worse admissions rate in the sample. It is worth highlighting that the team were only establishing themselves as a functioning CRT at the time these data were collected

It is not clear from the case study why this is the case. There appears to be no obvious link between the leadership in the team and the high hospital admission rates.

As discussed, in the first year the team initially started they were operating mainly as an assessment team, which meant they had little time for home treatment. This must have had implications for the team's effectiveness at reducing hospital admissions.

The team also have a very large catchment area, which may account to some extent for the high admission rates.

**Table H3.2**

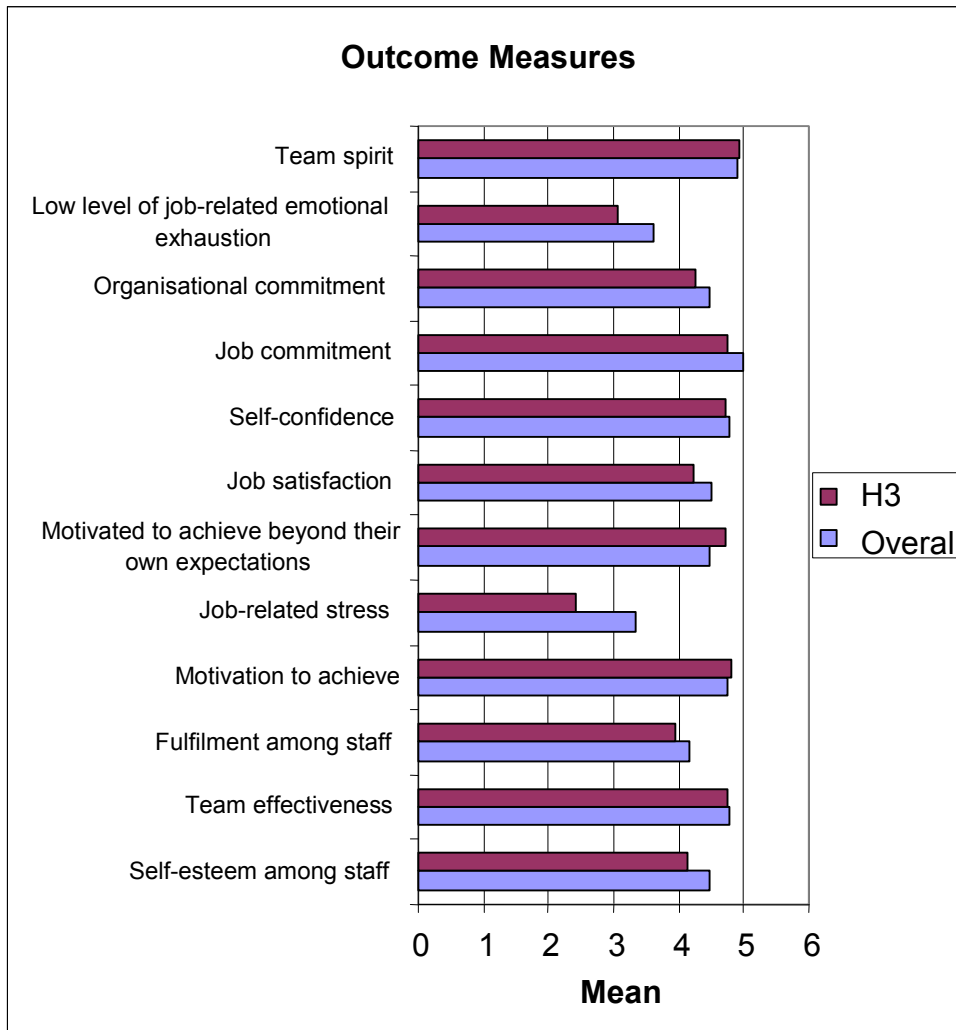
	<b>Referrals to the team</b>	<b>Assessments conducted by the team</b>	<b>Admissions to hospital made by the team</b>
<b>Apr-05</b>	58	58	40
<b>May-05</b>	58	58	52
<b>Jun-05</b>	58	58	56
<b>Jul-05</b>	58	58	57
<b>Aug-05</b>	58	58	45
<b>Sep-05</b>	58	58	48
<b>Oct-05</b>	58	58	46
<b>Nov-05</b>	58	58	51
<b>Dec-05</b>	58	58	44
<b>Jan-06</b>	58	58	57
<b>Feb-06</b>	58	58	40
<b>Mar-06</b>	58	58	46

*LCCI Outcome measures*



The LCCI outcome measures are presented graphically in Figure H3.2, with the more detailed results presented in Table H3.3. It can be seen from the results that whilst team H3's results are generally similar to the overall sample's, they have a more negative result on nine out of the twelve measures. It can be seen from the effect size differences that the team have poor outcomes in relation to emotional exhaustion ( $m=3.00$ ,  $SD=1.35$ ) and job related stress ( $m=2.42$ ,  $SD=1.09$ ).

**Figure H3.3**



**Table H3.3**

<b>LCCI Outcome Measures</b>							
	<b>Overall</b>			<b>H3</b>			<b>Effect size differences</b>
	<b>N</b>	<b>M</b>	<b>SD</b>	<b>N</b>	<b>M</b>	<b>SD</b>	
Self-esteem among staff	721	4.46	1.25	33	4.12	0.89	<b>-0.27</b>
Team effectiveness	725	4.78	1.12	34	4.74	0.75	<b>-0.04</b>
Fulfilment among staff	717	4.17	1.26	34	3.94	0.98	<b>-0.18</b>
Motivation to achieve	720	4.73	1.03	33	4.82	1.04	<b>0.08</b>
Job-related stress	712	3.35	1.47	33	2.42	1.09	<b>-0.63</b>
Motivated to achieve beyond their own expectations	692	4.48	1.10	32	4.72	1.08	<b>0.22</b>
Job satisfaction	712	4.51	1.23	34	4.24	1.13	<b>-0.22</b>
Self-confidence	714	4.78	1.02	34	4.71	0.91	<b>-0.07</b>
Job commitment	718	4.98	0.93	34	4.74	0.93	<b>-0.27</b>
Organisational commitment	719	4.46	1.07	34	4.26	0.96	<b>-0.18</b>
Low level of job-related emotional exhaustion	696	3.61	1.44	34	3.06	1.35	<b>-0.38</b>
Team spirit	720	4.89	1.20	34	4.94	0.92	<b>0.04</b>

## **Conclusion**

Team H3 has very high hospital admission rates, the reason for this is not clear. It is not possible to say whether this is due to leadership factors, or more practical aspects, such as the catchment area.

There are positive relationships in the team. However, the team seems more hierarchical than other case study teams, especially in relation to the presence of a senior management team; this is a cause of friction for some staff.

Whilst staff appeared to be happy with the team lead, there were some comments suggesting that the leader is sometimes quite controlling; again, this seems to be difficult for some staff.

The medical staff are part of the senior management team, and the team lead says she has good relationships with them. It was not very clear from the interviews how medically led the service is and what model the medics in the team subscribe to; this may have implications for hospital admissions. There was no real discussion of risk management, so it is not clear what is constituted as high-risk by the team.

## Emerging themes from the case studies

Here we discuss the key themes emerging from the case studies. We also explore issues relating to leadership culture and factors influencing hospital admissions.

### **Impact of Trust culture on team development**

The underlying culture within the Trust indicated the types of barriers and facilitators encountered by the CRT. This also determined how hard a team lead and other staff would have to work to assert the CRT ethos. For team L1 support from the PCT was unusually good having made mental health a priority. This made setting up the CRT much easier compared to other case study teams. L1 also develop protocols for service delivery with the PCT, which goes even further in terms of securing the ethos of crisis resolution, particularly when persuading external agencies of the need to cooperate. L2 also had the support of their locality where the team's vision for the CRT was shared with other agencies. This Trust was very positive towards crisis resolution. This resulted in less effort by L2 to create and maintain good relationships with external agencies. This team also appeared not to experience as many trust-imposed changes as other case study teams.

Perceptions of the dominance of the medical model was another factor that could hinder the CRT's practice and effectiveness, but an important characteristic of a CRT was that it should not be led by medical staff (at least not solely). Part of L5's vision incorporated this into its philosophy of care. Being medically focused was perceived as contrary to the best interests of the service user. For L5 the main problem was the difficulties with ward staff and other mental health services focus on the medical model. This CRT marks a trend away from medically led mental health care and challenges the usual hierarchical structure found within inpatient wards. What CRTs have established is the need for all professionals to work in partnership as equals if they are to provide an effective, user-centred service.

The leadership qualities of the team leads such as L5 reveal how good leadership can help change this culture of resistance. One approach was to phase incrementally some aspects of the CRT service, such as gate-keeping, which is often a source of contention between CRTs and ward consultant psychiatrists. So rather than impose or force ward staff to surrender gatekeeping activities, the team lead would be sensitive to the politics involved and resolve the issue over time. L2 also had to work hard with external agencies and assert the ethos of the CRT. For example, if a person was admitted to hospital inappropriately the team would strongly oppose it, so that the focus of care shifted towards treating people at home and not centred around a hospital admission.

### **Stability**

The introduction of the CRT brought with it new ways of working for people with mental health problems in crisis. The resulting changes were considerable, and how team leads managed these has already been discussed. Changes were needed from within mental health care services

generally and also within other agencies such as A&E departments, primary care and police stations. The relationships with CMHTs were especially problematic. Boundary issues and CRT function were often misunderstood. However, as teams run for longer they became more established and it was recognised that things became easier as less changes were imposed. Where changes were continuous teams found it more difficult to settle.

However, not all case study team leads viewed change as negative. Team L3 was about to be reconfigured and integrated with the acute inpatient service. This was in part to address the staffing problems and resource constraints the team had experienced since its inception. The team lead was very positive about these changes and felt it would take the CRT to a new level that would result in the team having more freedom to remodel itself and be more resourceful with the budget.

### **Control over running a service**

The amount of control a team lead had in running the service varied. This was dependent on factors such as the directives imposed by PCTs, budgetary constraints resulting in a lack of staff, and control over recruitment.

A lack of adequate funding was a significant problem for L3, which resulted in a shortfall of 50% in staffing levels. However, the team lead was resourceful, despite the substantial gap in staff. Admissions for this team were low, however. Inheriting staff was another key factor affecting the functioning of the team. Such staff were often resistant to adjusting to new ways of working and would later leave. This was the experience of team H1.

What is clear is how team leads and other team staff were able to make the most of what they had. Sometimes they were under a great deal of pressure to meet the demands of external agencies and the PCT. Team H2, for example, had their caseloads determined by the CMHT. This was an attempt to work flexibly with the CMHT. However, it had a negative impact on the team's effectiveness. Team H3 had, in some respects, compromised its autonomy in terms of regulating its own workload. Teams under this sort of pressure, including those considered 'low performing', were very resourceful and constructive in the way they approached conflict both within and external to the team.

### **Different styles of leadership**

With regard to leadership, the first issue to emerge is that having high quality leadership, as judged using the LCCI, does not guarantee having a low admissions rate; nor does low quality leadership necessarily mean that the admissions rate will be high. This is also true for attitudes to work and well-being at work scores.

As is evident from the quantitative analyses, contextual factors have a predominantly large effect on the performance of teams, judged in terms of admissions to in-patient care.

It is notable that for each team different styles of leadership emerge. It was interesting to explore what good leadership meant for individuals in the team. The team lead was clearly an important lead not just in terms of managing the team but often the person who laid the foundations during its development. These leads were very experienced practitioners and managers who had a clear vision of what a CRT should look like and how it should function. These highly skilled individuals were pivotal to the success of the CRT and knew how to support and empower staff, together with focusing on delivering an optimum service centred on the needs of service users.

A strong leadership style was evident for the lead of L2. Staff viewed this positively, although it was recognised that they had become over reliant on the team lead. This was evident when he was absent from the team for a period of time when the team morale decreased. This suggests that the team lead was perhaps less enabling than those who were more facilitative.

Being supportive and visionary was a common leadership style highlighted by many staff interviewed for the case studies. Acting as an advocate with external agencies, supporting staff on a personal and professional level was considered valuable and a source of strength.

'Hands on' leadership was considered crucial. The majority of the team leads considered it important to lead by example, help out when short-staffed and simply to be relied upon when needed.

### **Issue of non-medical leadership of teams**

The case studies raised the important issue of non-medical leadership and the role of the psychiatrist in CRTs. For example, what emerged from team L3 was the new role of the psychiatrist within the CRT. Clinical leadership was on a par with the practitioner-led CRT. Although specialist registrars and junior doctors preferred to be supervised by the consultant, but recognised the leadership skills of the team lead.

The Onyett *et al.* (2006) CRT survey found that many team managers conducted most of the key management tasks, particularly clinical supervision of team members, decisions on the client group, deciding which referrals to accept, building working relationship with relevant external agencies, and assessing the demand for CRT services, in the local community. The senior medical member of the team was the person responsible for over-ruling the clinical decisions of team members, if considered necessary. This suggests that much of the time the non-medical members of the team, particularly the team lead, made the majority of decisions relating to the CRTs day to day functioning.

Tan (2001) clarified the issue regarding the roles and function of psychiatry medical staff in a study comparing the views of medical and non-medical staff in two community mental health services. This study found there was good concordance between medical and non-medical staff where clinical roles were concerned. However, team and leadership roles were less well

conceptualised. Role confusion and role conflict were apparent between the two groups of team members. The doctor's *team* role has two components – a technical or clinical one, and a non-technical role which was poorly understood. Tan (2001) went on to explain that the Community Mental Health Clinic psychiatrist's leadership role also has two components – 'clinical leadership' (mainly a technical role) and 'team leadership' (involving the setting of goals for the team, persuading team members to take a particular direction, guiding people, and so forth).

In our study 'team leadership' as defined directly above was clearly performed by team leaders and not psychiatrists. Psychiatrists in the CRT tended to performed clinical leadership activities, which they acknowledged and therefore had less to do with managing the team as a whole.

New policy initiatives have introduced the 'New Ways of Working Programme', which includes enabling all workers to be flexible, to work in a team, and to focus on their skills rather than their status. This shifts away from traditional hierarchical structures within healthcare services in which there was a dominant medical model approach to delivering care. This shift also allows service user and carers to be equal partners in their care (CSIP/NIMHE, 2007). CRTs provide one example, where they work effectively, of good team working and of focusing on service users and carers.

### **Approach to risk management**

Risk is a particularly important issue for CRTs given its role in deciding whether a person should be admitted to hospital or not. Four of the case study teams referred to risk and how they managed this. Balancing safety and risk was a key theme for team H2. What emerged from this team was how different professionals had different thresholds for risk. Experienced nurses, use to dealing with crisis situations, had the highest risk thresholds. Social workers and newly trained professionals had much lower thresholds for risk. This was an issue that was discussed regularly within teams and positive risk taking was seen as an important part of what CRTs do. Sharing and discussing caseloads was also considered important for managing issues of risk, particularly when team members worked on shifts or were relatively autonomous. How teams classify risk may have some bearing on whether their admissions to hospital are likely to be higher or not. None of the teams mentioned this, but it nevertheless raises some interesting questions.

### **Working as a whole unit**

Team leads were keen to ensure the team worked as a whole unit. Division or team fragmentation was regarded as potentially negative. Many of case study teams had 'flattened' hierarchies. This lack of hierarchy was a deliberate strategy by the team lead for L2 to ensure the team worked as an integrated unit, despite differences in team members' qualifications and experience. Occasionally, as in team H3, the existence of a senior management section may have worked against facilitating shared-decision making. For team L5 cohesiveness was important to achieving the goals of crisis care.

Team H3 had a large team of 36 staff to cover a huge geographical area. The size of the team may have contributed to the lack of cohesion and communication within it, despite reports of good internal relationships.

### **Multidimensional team lead**

The skills of the team lead were often required to stretch beyond their background training and management experience. Having a well-developed business role appeared equally important. For example, the team lead for L5 had to work tirelessly to negotiate funding from the PCT and be creative with the very limited resources provided. This was alongside his clinical, leadership and managerial roles; a role the team lead was not always comfortable with.

### **Integrated crisis services**

Two of the case study teams were integrated crisis services, which had brought together the inpatient ward and community services (teams H1 and L4). This was described as working in a whole systems way. Whilst team H1 had a high number of admissions, in contrast L4 had the lowest admissions rate of all the case study teams (only two during an eight month period). The differences between these two teams appear minimal at first glance. Both were very committed and motivated to providing the full spectrum of crisis and home treatment care that was service user centred. Team H4, however, appeared to have more problems with the PCT. One possible explanation concerns attitudes towards admitting people to hospital; perhaps team H4's attitude was more 'relaxed' compared to other case study teams. Certainly this team's emphasis appeared to be on early discharge and good continuity of care rather than preventing admission to hospital.

The leadership scales for team H1 were extremely good. The same scores for team L4, however, were surprisingly poor. Attempts to explain this finding can only be speculative. It may be related to the low response rate for the LCCI inventory for L4 team members, resulting in an unrepresentative picture of leadership culture. It could also be the role of the acute care manager for L4 focused on keeping the four components of the service together and only able to provide a very distant type of leadership for many of the staff.

### **Summary of the case studies**

The present study reveals that the development of CRTs has been a daunting process for the team leaders. They have instilled shared vision to their team, and these multidisciplinary teams have been passionate about the key aspects of patient centred care. The teams are thoroughly committed to the care of their clients, and mostly derived their job satisfaction from the personal contact with the clients. Seeing an improvement in the life of their clients has made them more committed to their work. Team leaders have been successful in coping with managing the change that they have had to deal with.

The team leads have had various contextual factors that, to a greater or lesser extent, have been beyond their control. One such contextual factor includes Trust support. Apart from simply providing the MHPIG guidelines, it would

have been better if more support and clear policies had been readily available at the trust level. Most of the time team leaders have been left to muddle through the process. Senior management decisions, and the political climate at trust level, have impacted strongly on the successful implementation of this new service. Funding resources have also been an extremely important issue in enabling teams to function to their full potential. The initial setting up of the CRTs could have been managed better at the trust level.

Related to the above, is the quantity and composition of the staff available to the CRTs. The success of the team operation depended, in part, on getting the appropriate skill mix. Not all the CRTs had the full skill mix of staff that they were meant to have. The multidisciplinary nature of the CRTs has been a positive aspect in promoting team work. This has been a significant factor in encouraging the teams to discuss different approaches from the different discipline, and has helped in the care they can offer their clients.

A whole systems approach is much needed for the teams to function well. Confusion caused from external services could have been avoided if, initially, these services had been given clear information as to why and how the new CRT was going to function. Team leaders have tried hard to make other services aware of their role, and this continues to be something they engage in. The team leaders feel this should have come clearly from the senior management. One of the problems has been the traditional 'medical model' and 'hierarchical structure', which has made it difficult for the teams to go forward. All the team leaders are committed, and feel that treating clients in the community is a much needed improvement.

In summary, the positive aspects of CRTs were seen as: support from the team lead and from other team members; a clear vision shared by all members of the team that forms the basis of their service delivery; multidisciplinary working; skills & experience of the staff; commitment to the service; team building & communication; and team working. The areas where improvements were needed were: adequate resources; appropriate staffing levels; greater support at trust level; more cooperation from external services; training for both team leaders and staff; more whole system working; more 'dedicated' consultants; more communication with external agencies; and enhanced gate-keeping role.



## SECTION 7 – DISCUSSION

The purpose of this longitudinal study was to examine the impact of leadership factors in implementing change in complex health and social care environments, within the context of the NHS Plan clinical priority for mental health crises resolution teams (CRTs). The analyses were undertaken within the wider context of asking the question: What aspects of leadership in multi-professional organisations contribute to effective change management?

In order to address the issues, assessments were made of: - the leadership quality that exists within CRTs; attitudes to work and well-being of staff; a range of contextual factors likely to affect team performance; and the success of the team in reducing the proportion of service users referred for in-patient care.

In assessing leadership quality, there was cognisance of current thinking about the nature of leadership, particularly 'distributed' leadership, and about how it can validly be assessed. The selection of a leadership assessment tool was guided by the empirical, grounded theory research into 'engaging' or post-heroic 'transformational' leadership undertaken by Alban-Metcalfe & Alimo-Metcalfe (2007) and Alimo-Metcalfe & Alban-Metcalfe (2001; 2005a; 2006a). This 'model' of leadership, while recognising that leaders must demonstrate appropriate levels of the required *competencies* or *skills* for their role, reflects a style of leadership that is characterised by being active in *engaging* with others as individuals, *engaging* with the organisation, and *engaging* with the community. It is an approach to leadership that is predicated on partnership, openness, connectivity, a sense of humility and humanity, treating people with dignity, encouraging a questioning of the *status quo*, building a shared vision, and actions which always reflect integrity.

### Leadership Climate and Change Inventory (LCCI)

The 'Leadership Climate and Change Inventory (LCCI) was adopted to study the quality of the leadership of the teams, since it assesses both competent and engaging leadership behaviour, and is predicated on a 'distributed' concept of leadership. Exploratory and confirmatory principal components analyses of the LCCI, among 731 team members, suggested that two dimensions of engaging or 'post-heroic transformational' leadership behaviour can be assessed, along with one dimension of competent or skilled leadership behaviour, among staff working in CRTs. The teams are multi-professional in nature and are comprised primarily of psychiatrists, nurses, social workers, occupational therapists and support staff, all of whom completed the LCCI.

Three dimensions of leadership behaviour were identified: 'Scale 1: Engaging with Others' (16 items); 'Scale 2: Visionary Leadership' (7 items); 'Scale 3: Leadership Capabilities' (14 items), each of which showed a high level of internal consistency ( $\alpha \geq .89$ ; inter-item  $r \geq 0.36$ ). The inter-correlations between the three scales ranged from  $r = .82$  to  $.91$ , suggesting a high level of co-linearity. However, each scale was treated separately in subsequent

calculations. The test-retest data revealed that the mean scores on 'Scale 1: Engaging with Others', but not on the other two scales, decreased significantly over time ( $p < .001$ ). This was also true in the cases of four of the attitudes to work *facets* ( $p < .05$ ) and four of the *facets* of well-being at work ( $p < .05$ ), though not in the case of 'reduction in job-related stress', where the mean rating was higher ( $p = .019$ ). The test-retest coefficients for the three leadership scales were  $r = .62$ ,  $r = .44$ ,  $r = .49$ , respectively. These are of the same order of magnitude as the test-retest coefficients for the *facets* (range  $r = .33$  to  $.49$ ). The instrument is, therefore, statistically significantly reliable over a period of 12-18 months ( $p < .001$ ).

In that the provenance of the scale 1 and scale 2 items is the grounded theory-based research involving a large and inclusive sample of managers and professionals working in local government and the NHS (Alimo-Metcalfe & Alban-Metcalfe (2001), and the provenance of scale 3 items is the perceptions of professionals working in the NHS, the LCCI can be regarded as having a high level of content validity. Also, in that the items that comprise scales 1 and 2 can be related to the concept of nearby 'transformational' leadership evident in other studies (see Alimo-Metcalfe & Alban-Metcalfe, 2005a, 2006a, for reviews) the LCCI™ can be seen to demonstrate construct validity. For the present sample of staff working in CRTs, the significant correlations with the *facets* of attitudes to work and well-being at work ( $p < .001$ , in each case), and the results of the multiple regression analyses suggest, further, that the LCCI demonstrates significant concurrent and discriminant validity.

### **Hypothesis 1: Leadership and Team Effectiveness**

The overall hypothesis, Hypothesis 1, which states that the quality of leadership exhibited by the leaders of Crisis Resolution Teams is directly related to team effectiveness, was tested through one subsidiary hypothesis (Hypothesis 2) concerned with the relationship between quality of leadership and staff attitudes to, and sense of well-being at, work, and four subsidiary hypotheses concerning the relationship between quality of leadership and team performance (Hypotheses 3 – 6).

The extent to which there is support for Hypothesis 1 can be judged in relation to the extent to which these subsidiary hypotheses hold true.

### **Hypothesis 2: Leadership and Attitudes and Well-being**

Hypothesis 2 states that the quality of leadership of CRTs is positively associated with staff attitudes to work and well-being at work.

This (person-related) aspect of team effectiveness was tested by examining the extent to which the quality of leadership of CRTs is positively associated with five *facets* of attitudes to work and seven *facets* of well-being at work, all of which relate directly to notions of 'engagement', and include attitudes to

work that have been identified as having a significant effect on organisational performance (e.g. Patterson, Warr & West, 2004; Xenikou & Simosi, 2005).

The sources of the data were: (1) product-moment correlations between the three leadership scales and the person-related dependent variables (staff attitudes to work and well-being at work); (2) stepwise multiple regression analyses between each of the leadership scales and the person-related dependent variables; and (3) hierarchical regression analyses between each of the leadership scales and the person-related dependent variables, controlling for the effect of contextual factors.

The product-moment correlations between each of the three leadership scales and each of the *facets* of attitudes to work or well-being at work (range  $r = 0.41$  to  $r = 0.75$ ) were all significant beyond the 0.01 per cent level. These are of the same order of magnitude as in other comparable studies (e.g., Alimo-Metcalfe & Alban-Metcalfe, 2001; Borrill *et al.*, 2005a & b; Parker *et al.*, 2003; Patterson *et al.*, 2004), and suggest a high level of convergent validity.

As noted earlier, it has been suggested that the use of same source data tends to inflate the magnitude of correlation coefficients, owing to common method variance (CMV). On the other hand, Spector (2006) has suggested that the evidence for this is by no means unequivocal, and having discussed theoretical reasons for and against expecting it to affect results, goes so far as to describe CMV as possibly being an “urban legend”.

What can be pointed to is that, where the use of split-half data has been used in a study comparable to the present one, the results when the data were split and when they were not split, were not significantly different (e.g., Patterson *et al.*, 2004). Accordingly, no corrections were made in analysing the present data.

Stepwise multiple regressions analyses indicated that ‘Scale 1: Engaging with Others’ is a significant predictor of each of the twelve person-related dependent variables. However, the other ‘transformational’ scale, ‘Scale 2: Visionary Leadership’ was a significant predictor of only one of the attitude to work scores (‘motivation to achieve’), but of five of the well-being scores (‘sense of fulfilment among staff’, ‘self esteem among staff’, ‘reduced job-related stress’, ‘reduced job-related emotional exhaustion’, ‘sense of team effectiveness’).

‘Scale 3: Leadership Capabilities’ predicted three aspects of the attitude to job ‘satisfaction’ and the two measures of ‘motivation’, but not ‘job commitment’ or ‘organisational commitment’, and ‘self-confidence’ and ‘sense of team effectiveness’.

Therefore, consistently with other relevant studies, leadership quality, as measured by the LCCI is a significant predictor of staff’s attitudes to work and their sense of well-being at work, though different patterns of relationships exist between the independent and dependent variables (e.g., Alban-Metcalfe & Alimo-Metcalfe, 2000a & b). What the data also suggest is that, of the three

dimensions identified, the leadership quality of *engaging with others* (Scale 1) is the best predictor of attitudes to work and well-being at work. Indeed, given the aspects of leadership that this scale assesses (as reflected in the items), it would be difficult to expect otherwise.

The results for the other two scales are also interpretable in terms of the items that comprise these scales. The existence of systems and processes that operate effectively and function efficiently provides a well-defined structure within which staff can take decisions and make predictions with a measure of confidence. Consistently with this, the significant relationships between 'Scale 3: Leadership Capabilities' and the *facets* 'job satisfaction', 'motivation to achieve', and 'motivation to achieve beyond expectations', are readily interpretable, as is the significant relationship with 'self-confidence' and 'a sense of team effectiveness'.

While scores on 'Scale 2: Visionary Leadership' emerge as significant predictors of 'motivation to achieve', they are associated more with five aspects of well-being at work. Thus, the statistically significant relationships with each of these *facets* (sense of fulfilment; self-esteem; reduced job-related stress; reduced emotional exhaustion; sense of team effectiveness) may be interpretable in terms of the team having a sense of vision; but not just 'a vision', but rather a vision with which staff can identify, and towards the realisation of which they are encouraged to contribute.

It is also important to recognise that engaging or 'post-heroic transformational' *and* competent leadership are *both* significant contributors to staff attitudes to their work and to their sense of well-being at work.

The hierarchical multiple regression analyses reported in Appendix 4 suggests that, with the exception of 'reduced stress', relationships between staff self-ratings in relation to each of these person-related *facets* and leadership quality cannot be attributed to the effect of contextual factors. In other words, the different contexts in which the different teams operate do not, for the most part, affect the positive effect of leadership quality on staff attitudes to work and their sense of well-being at work.

Formally, there is support for Hypothesis 2.

### **Hypotheses 3 and 4: Leadership and Organisational Performance**

Hypothesis 3 is that the quality of leadership of CRTs is positively associated with a higher *ratio* of the number of assessments made by the team in relation to the number of referrals for in-patient care,<sup>15</sup> while hypothesis 4 is that the quality of leadership of CRTs is positively associated with a *change* in the

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<sup>15</sup> **Ratio** was defined as the number of assessments made by the team to the number of referrals for in-patient care as an average over a 12-month period. A *low* score indicates fewer in-patient referrals per assessment.

ratio of the number of assessments made by the team in relation to number of referrals for in-patient care, over a 12-month period.<sup>16</sup>

These hypotheses were tested in three ways: - through analysis of variance; by calculating product-moment correlations; and by undertaking hierarchical multiple regression analyses. One-way analysis of variance calculations of staff's ratings on each of the three leadership scales were conducted with the sample divided into high *versus* moderate *versus* low performing teams, with reference (a) to 'ratio' scores, and (b) to 'change' scores.

Analysis of variance and *post hoc* application of the Tukey HSD test suggests that the average quality of leadership scores for the high performing team, defined as the one with the *lowest* average number of referrals to in-patient care in relation to assessments undertaken ('ratio' score), were significantly higher than for both the moderate and low performing teams ( $p < .037$ ;  $p < .02$ ), though only in the case of 'Scale 1: Engaging with Others'.

This evidence is consistent with support for Hypothesis 3.

Analysis of variance of the 'change' scores did not provide evidence that leadership quality was significantly related to any change in the 'ratio', which suggests rejection of Hypothesis 4.

Furthermore, calculation of product-moment correlations between each of the three leadership scores and (a) 'ratio', and (b) 'change' scores, did not provide support for either Hypothesis 3 or Hypothesis 4.

Similarly, there was no support for the hypothesis when hierarchical multiple regression analyses were undertaken among a total of 46 teams to determine the relationship between (a) 'ratio', and (b) 'change' scores and leadership quality, when the effect of staff attitudes to work, staff well-being at work, and contextual variables that might affect the performance of the team, were taken into account.

As neither the product-moment correlation coefficients, nor the hierarchical multiple regression analyses, confirm the results of the analysis of variance, the suggestion of support for Hypothesis 3 must be treated with a degree of caution. Analysis of variance is a relatively 'crude' statistic, and the probabilities are only beyond the 5 per cent level. Furthermore, there is the evidence, noted above, of month-by-month variations in the 'ratio' scores. Thirdly, being based on *mean* scores, what the statistic does allow for is that, as one of the Case Studies illustrates, a team could be successful in reducing bed occupancy for reasons other than the quality of its leadership.

However, what is clear is that the hierarchical regression analyses provide evidence that contextual factors do have a significant effect on the performance of CRTs. Furthermore, these factors, which are largely, and in

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<sup>16</sup> **Change** was defined as any difference in the 'ratio' over a twelve month period. A *high* score indicates greater effectiveness.

many cases wholly, outside the control of the team, are so great as to prevent quality of leadership from impacting on team performance (as measured by the metric of 'ratio' or 'change') to such a degree that any effect cannot be detected.

The results for the 'ratio' of assessments to in-patient referrals results are informative in that they suggest a significant impact on performance was attributable positively to: - the availability of alternatives to in-bed provision ( $p < .001$ ); having more team members dealing with a given case ( $p < .001$ ); greater gate-keeping control ( $p < .001$ ); greater extent of service cover ( $p < .001$ ); and the 'recency' of team formation ( $p < .001$ ).

Negative effects appeared to be attributable to: - the greater the extent of psychiatrist involvement ( $p < .001$ ); and the greater the number of different professions represented within a team ( $p < .001$ ). Neither the proportion of service users who present symptoms of psychosis, nor the MINI score for the locality, nor any of the six *facets* of attitude to work or well-being at work appeared to have any significant effect.

It may be the case that the negative effects are a consequence of risk assessment thresholds which seem to differ between professionals within the team. In one of the case studies, senior nurse practitioners were seen to have quite high thresholds for risk, whereas social workers, newly qualified staff and possibly psychiatrists were much more cautious and therefore more likely to admit someone to hospital than default to crisis resolution/home treatment. This issue is addressed in the Approaches to Risk Management section in the Emerging Themes from the Case Studies section of Chapter 6 and team H2 case study (a high admission team) where this is described in the section on Balancing Risk and Safety.

A similar picture emerged when 'change' was the dependent variable, except that: - the age of the team no longer continued to have a significant effect; greater gate-keeping control was associated with lowering the effect on changing the admissions/referrals ratio; the extent of psychiatrist involvement no longer continued to have a significant effect; and the extent of service cover no longer continued to have a significant effect ( $p < .05$ ). The relevance of this last finding may be that, as Onyett *et al.* (2006) suggest, some rural services do not need out of hours cover as local stakeholders do not seem to require it.

All this information is of signal importance in continuing to guide planning into the nature and extent of crisis resolution and home treatment services. In relation to the thesis of the present study, however, the super-ordinate issue is the great extent to which factors that are largely, if not wholly, outside the control of the leadership of a team can have a profound effect both on proportion of service users admitted to in-patient care, and on any changes in that ratio.

## Hypothesis 5 and Hypothesis 6: Team Performance

Hypothesis 5 states that the quality of leadership of CRTs is positively associated with higher *productivity*, which reflects a higher ratio of assessments made by the team to referrals to in-patient care, as a function of the ratio of staff to service users.<sup>17</sup> Hypothesis 6 is that the quality of leadership of CRTs is positively associated with a *change in productivity*, as measured by an increase in the ratio of the number of assessments made by the team in relation to number of referrals to in-patient care, over a 12-month period, as a function of the ratio of staff to service users.<sup>18</sup>

None of the product-moment correlation coefficients between each of the leadership quality scales and (a) 'productivity', and (b) 'change in productivity', reached the 5 per cent level of statistical significance. However, hierarchical multiple regression analysis revealed that, while several of the contextual variables continue to have a significant impact on 'productivity', so too did an *engaging* style of leadership ('Scale 1: Engaging with Others'). This last relationship was not evident when the dependent variable was 'change in productivity'; nor was either of the other two leadership scales significantly related either to 'productivity' or to 'change in productivity'.

As far as the 'productivity' of the teams is concerned, these results appear to suggest that it is affected positively by: - the availability of alternatives to in-bed provision ( $p < .01$ ); the greater the number of team members dealing with a given case ( $p < .001$ ); the more gate-keeping control that a team has ( $p < .001$ ); the greater the extent of psychiatrist involvement ( $p < .001$ ); the greater the extent of service cover ( $p < .001$ ); and recency of team formation ( $p < .001$ ), along with quality of the leadership, measured in terms of engaging with staff ( $p < .05$ ).

Conversely, the proportion of service users who present symptoms of psychosis had a negative effect on 'productivity' ( $p < .001$ ), while no effect was attributable to either the MINI score for the area in which the team is located, the number of different professions represented within the team, or any of the six *facets* of attitude to work or well-being at work.

Analysis of the results in terms of 'change in productivity' appears to suggest that it is positively associated with the availability of alternatives to in-bed provision ( $p < .001$ ), and the greater the number of team members dealing with a given case ( $p < .001$ ).

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<sup>17</sup> **Productivity** was calculated by dividing the 'ratio' scores by the ratio of the number of assessments made by the number of members of the team. A *low* score indicates higher 'productivity'.

<sup>18</sup> **Change in productivity** was calculated by comparing the average 'productivity' during months 1 and 2 with that during months 11 and 12. A *high* score indicates higher 'productivity'.

Negative effects appear to be attributable to: - a higher proportion of service users who present symptoms of psychosis ( $p < .01$ ); a higher MINI score for the area in which the team is located ( $p < .001$ ); the greater the extent of psychiatrist involvement ( $p < .05$ ); the greater the number of different professions represented within the team ( $p < .001$ ); and self-perceptions of a reduced level of job-related stress ( $p < .01$ ).

Neither the age of the team, nor the degree of gate-keeping control, nor the amount of service cover, nor any of the other five of the six *facets* of attitude to work or well-being at work, appeared to affect 'change in productivity'.

What emerges here is evidence that 'productivity' and 'change in productivity' are affected to a significant extent by the contextual factors that have been measured. Some of these factors have a positive effect, while others have a negative effect. The only counter-intuitive finding is the significant negative relationship between 'change in productivity' and 'reduced stress'. One possible explanation is that achieving greater productivity is itself a stressful activity, over which the quality of the leadership appears to have no quantifiable effect.

The results of the structural equation modelling of the results may shed some light on this seemingly paradoxical finding. As shown in the model, 'Scale 1: Engaging with Others' (SCALE1) (scored positively) is significantly associated increased 'job satisfaction' (JOBSAT), 'motivation to achieve' (ACHIEV), 'job commitment' (JOBCOM), and 'reduced stress' (STRESS) (all scored positively). SCALE1 is also a significant predictor of with 'productivity' (ASSESSM\_C) (scored negatively), such that the greater the quality of leadership, the greater the level of 'productivity'. However, again counter-intuitively, high levels of 'motivation to achieve' (ACHIEV) are associated with lower levels of 'productivity'.

The relationships between SCALE1 and each of the three facets of attitudes to work (JOBSSAT; ACHIEVE; JOBCOM) and the one *facet* of well-being at work (STRESS) are as predicted, as is the relationship with 'productivity' (ASSESS\_C). What is not readily interpretable is why 'motivation to achieve' should be associated with lower 'productivity'. Here, two lines of interpretation are informative.

One, is that there is evidence of the influence of 'substitutes for leadership' (Kerr & Jermier, 1978). This concept suggests that certain personal factors (e.g., high need for independence, indifference to organisational rewards, or a professional orientation) and contextual factors (e.g., work group autonomy, or routine or programmed work) can have a moderating effect on leadership behaviour (e.g., Bass, 1990; Gronn, 1999; Howell, 1997; Howell, Dorfman & Kerr, 1986; Jermier & Kerr, 1997; Kerr & Jermier, 1978; Podsakoff & MacKenzie, 1997). In other words, for some individuals, or for some individuals in certain contexts, the way in which other people interact with them does not affect their behaviour to a significant extent, whether it be in a work-related or other situation. Such individuals may be thought of as the



kind of person whose motivation is mostly, if not exclusively, internal, and for whom external 'reinforcement' does not impact on what they do.

Empirical evidence of the effect of this came in a study by Stordeur, Vandenberghe and D'Hoore (1999) among nurses in a Belgium hospital. They examined the relationship between leadership scores (measured using the MLQ) and the four criterion variables, including job satisfaction and satisfaction with leadership style, and found evidence to suggest that substitutes for leadership can have a significant moderating effect.

Applied to the context of CRTs, and to the kind of individuals that elect to work in them, it is easy to anticipate that a significant number of CRT staff are the kind of person whose motivation to succeed is principally intrinsic in origin. Such motivation could equally have its origin in deeply-held personal or professional values, or a combination of both. Furthermore, the context in which CRT staff operate, in which, unlike in-patient care, is one in which they have to deal not only with the service user, but also her/his family, is such that having an 'independent' attitude is likely to be beneficial to the performance of one's job.

Judging by the qualitative, case study data, staff are very clear about their purpose and what they need to deliver, and are committed to the idea of keeping people out of hospital. We know less about the *actual* work CRTs do with families, except that they say that they do support them. There is still no research detailing the benefits of this service for families. CRT staff are clearly very motivated and service user centred.

It may be the case that the individuals most affected by the leadership of the CRT are those individuals who do not have high levels of motivation. If this is the case, then this may have important implications in the wider context of the NHS and elsewhere.

As was referred to earlier in this section, a study by Towers Perrin (2005) found a significant relationship between levels of employee engagement in organizations and financial success. In that same study, basing the analyses on purely UK data from around 5,000 employees, the same report described the typical breakdown of engagement levels in organizations as:

- 15% highly engaged
- 20% 'disengaged' or low levels of engagement, but
- 65%, on average, in most organizations, were between low and moderate.

They made the point that the large reservoir of staff (65%) who were 'moderately' engaged at best, formed a crucial pool of potential on whom to focus engagement techniques, since they could sway either way. That is, they could move backwards in engagement terms, and exert a powerful negative impact on morale, and possibly subsequent performance, in the organization. But alternatively, they could be 'targeted' in attempts to increase their experience of engagement, which could have an exponentially positive impact

on morale and performance. Among the factors they identified as affecting engagement, were:

- excellence in people management, which includes ensuring there are good communication channels between senior managers and staff throughout the organization
- ensuring that people at every level in the organization are clear about how their role is critical for organizational success
- providing high levels of autonomy to individuals in their jobs
- encouraging staff to use their discretion, and to make decisions, and to take responsibility for their own specific functions

They maintain that the latter features of a job will maximize the sense of enrichment a job provides.

It is interesting to note that a brief article in a recent issue of *The Health Service Journal* (11 Jan 2007, p.31) refers to at least one significant financial benefit achieved of engaging staff in The Leeds Mental Health Trust. Apparently staff identified ways of making savings of £1.8 million in the year, and believed that a further £1.8 million could be saved. How was this achieved? The answer appears to be “from focusing on outcomes and changing a culture of blame to one of support – and encouraging staff to take responsibility for the trust’s success” (*ibid.*).

While this is heartening, we have also obtained worrying data from aggregating the anonymous ratings provided of staff of over 2,000 senior managers in the NHS who have undertaken the 360-feedback instrument we developed from our research into leadership, The Transformational Leadership Questionnaire (TLQ). The average ratings were particularly low for several dimensions that have been shown to predict motivation, job satisfaction, commitment, and reduced job-related stress. Two of these dimensions were ‘Showing Genuine Concern [for staff as individuals]’, and ‘Supporting a Developmental Culture’ (Alimo-Metcalfe & Alban-Metcalfe, 2003). Given the now well-established relationship between the leadership style of senior managers, and the culture of an organisation (e.g. Bass, 1998; Schein, 1985;1990), together with the evidence that one of the most important variables contributing to ‘engagement’ is the influence of the employee’s line manager, (Harter, Schmidt, & Keyes, 2002; Judge, Thorensen, Bono & Patton, 2001), the importance of creating a more transformational and engaging approach to leadership would appear to be a top priority for the NHS.

Formally, therefore, there is support for Hypothesis 5, through only in the case of ‘Scale 1 – Engaging with Others’. Using this scale to assess leadership behaviour, there is support for the suggestion that the greater the quality of the leadership of the team, the higher its level of ‘productivity’. However, hypothesis 6, concerned with any ‘change in productivity’ over time, must be rejected.

Support for hypothesis 5 can be interpreted as providing empirical evidence, under controlled conditions, that are consistent with the findings of the Sirota Survey (2005) and the assertions of Watson Wyatt (2005). An engaging style of leadership, as defined by Towers Perrin (2005), and as assessed using the metric of the LCCI, emerges as being significantly correlated with organisational performance.

### **Hypothesis 7: Transformational Leadership and Transformational Change Management**

Hypothesis 7 states that a more enabling or transformational style of leadership will be associated with a more transformational approach to managing change. In the event, it was not possible to provide quantitative evidence for or against this hypothesis. The qualitative research also does not provide an answer to this hypotheses, as it was not possible to discriminate between the team leads' approaches to managing change as they all talked as though they approached change management in a transformational style (i.e., continuous, iterative), rather than a 'transactional' (incremental; or 'unfreeze-move-freeze') approach to managing change.

Our results support the view that mental health services face continual change. Other writers have commented on how change in psychiatry is not unusual, and that CRTs come well within the pressures for change and the new drivers to improve the quality of mental health care, consumerism, and better integration of services (Callaly & Arya, 2005). Descriptions of how CRTs were introduced and set up in a Trust uncovered the importance of support and commitment from the PCT. The team lead, depending on whether they were involved in the implementation of the CRT, or arrived after its establishment, needed to be experienced and highly skilled. Skills such as implementing policy, formulating business plans, settling conflicts, and negotiating funding, were crucial for the job. Often these skills were not formally learnt.

The application of, or more often the lack of, change management models used by team leads appears to fit with the notion that psychiatrists may find the jargon used in this field a barrier to what they want to achieve, or that the models are too simplistic and formulaic (Callaly & Arya, 2005). A pragmatic approach was preferred, and any formal models that were applied were done so loosely. Interestingly, team leads did not appear to focus on barriers for change in their descriptions; instead they sought to resolve difficulties with a view to overcoming them. The attitudes of team leads were highly positive, and this seemingly caused them to be successful in achieving the goals of the team.

### **Summary of Case Study Findings**

Eight main themes emerged from the case studies, and the salient points within these themes are summarised as follows:

- the extent to which teams are successful in achieving their targets, depends to a very great extent on external relations with a range of stakeholders with which they have to operate;
- the existence of mutually agreed protocols is beneficial to the smooth-running and effectiveness of teams;
- linked to this, there is the need both for definition of, and adherence to, the boundaries between the responsibilities of different agencies (CRTs, CMHTs, GPs, A&E, &c.) working with different groups of service users;
- there is the need for many teams to have a greater sense of stability, though it was also evident that change can be a stimulus to greater achievement;
- good leadership can overcome resistance to change;
- teams were conspicuous in making effective use of resources, which were often limited;
- where medical models of provision dominate, they can have a deleterious effect on performance;
- related to this, contextual factors (including those referred to here), over which the team has no control, can have a supervening influence;
- team leads are seen as more credible when they show that they too are able to work directly with service users;
- teams were seen to work best where there were 'flat' hierarchies, and 'whole team' approaches were adopted to dealing with issues;
- related to this, having a senior management team that tended to be remote from the rest of the team had a debilitating effect;
- good leadership, which includes having a vision, networking, and managing in an efficient and supportive way, is fundamental to being an effective team;
- the extent to which different team members were willing to take risks was related to their personal confidence, which was, in turn, related to the nature of, and the amount of, experience that they had, and also the support they received in the workplace;
- teams' attitudes to in-patient care – specifically, whether or not they regarded admission as an absolute last resort – appeared to be relevant to admission rates;
- good leadership on its own does not guarantee low admissions rates.

### **Comparison between LCCL and Case study Data**

The last three bullet points above, in particular, serve to highlight an apparent contradiction in the qualitative and quantitative findings, arising from those case study teams which were successful in reducing admissions rates, but where the leadership quality was lower than the average for the sample as a whole.

What both sets of findings show very strongly is (1) the very strong impact that the context in which teams operate can have on team performance, and (2)

that such factors can, in some circumstances, be stronger than the influence of the leadership of the team. It was anticipated that factors such as the range of professions represented within a team, the MINI score for the locality, and gatekeeping, would affect performance. What the case studies additionally point to is the influence of some additional factors, including external factors, such as relationships with the PCT or CMHT, and the existence (or absence) of agreed protocols, and internal factors such as the willingness of staff to take risks, and the extent to which staff regarded admission to in-patient care as an absolute last resort. The issue of risk taking is worth underlining in this context. It was noted that, where non-clinical members of staff had little experience, or limited training, in dealing with patients with a mental illness, they were more likely to recommend admission than where the staff member had the benefit of specialist training, coupled with extensive practical experience. This, in itself, has important implications for future practice.

At a more general level, the case studies were chosen so as to be exemplars of teams that were relatively successful or relatively unsuccessful in meeting the government target; they were not examples of teams with high quality leadership. Within this context, quantitative correlational and other inferential statistical data serve to provide evidence of *patterns* of relationship between variables – in this case, quality of leadership and both staff attitudes and well-being, and organisational performance. Except when correlations or other statistics show a 100 per cent link between two variables (corresponding to  $r = 1.0$ ), it is inevitably the case that some counterfactual evidence will emerge.

### **Hypothesis 1 revisited**

Hypothesis 1 stated that the quality of leadership exhibited by the leaders of crisis resolution teams is directly related to team effectiveness. As noted above, the extent to which there is empirical support for this hypothesis is contingent on the extent to which Hypotheses 2 – 6 are upheld.

As far as the effect of leadership behaviour on staff attitudes to work and staff well-being at work are concerned (Hypothesis 2), Hypothesis 1 is supported.

With regard to the impact of leadership behaviour on organisational performance, the results are equivocal. On the one hand, there is some support, at a team level, for the hypothesised link with performance, judged in terms of the extent to which teams were successful in being able to treat service users in the community, rather than through in-patient provision (Hypothesis 3). On the other hand, there was no evidence of any change in their level of 'success' over a twelve-month period (Hypothesis 4).

When organisational performance was measured in terms of productivity, there was support for the hypothesis (Hypothesis 5) of a significant link with quality of leadership, but again, there was no evidence that leadership quality led to an increase in productivity over one year (Hypothesis 6).

As far as organisational performance is concerned, the substantive point would seem to be: Does leadership quality have a significant impact? The response is most relevantly judged in relation to Hypotheses 3 and 5, both of which suggest leadership behaviour at Time 1 is positively associated with subsequent performance. The fact that there is no evidence that such behaviour leads to an *increase* in performance over a one-year period, while interesting – even regrettable – does not negate the positive findings.

As discussed earlier, it is not possible to draw any conclusions about hypothesis 7, that is, that a more enabling or transformational style of leadership is associated with a more transformational approach to managing change. All the team leads in the qualitative research demonstrated a transformational style of leadership, so no comparisons could be made.

In conclusion, then, for the reasons discussed, we would suggest that Hypothesis 1 is supported.

At the same time, both the quantitative and the qualitative (case study) data point to the strong conclusion that, while quality of leadership does have a significant effect on performance overall,

- 1) context factors, both of the kind that were quantified in the present study, and those that emerged from the case studies, can have an even greater impact; and
- (2) in individual cases, the contextual factors can supervene.

### **Strengths of the Study**

The strengths of the study include that it reflected a major focus on leadership in a context of significant health policy development. Coupled with this, it constituted a large scale analysis of leadership in healthcare services, in which there was an emphasis on team functioning.

As such, it provided empirical, statistically significant evidence of the way in which leadership quality can have a significant impact on staff attitudes and their well-being at work, and on organisational performance. Because the findings were based on longitudinal, national research on teams that (1) are multi-professional in their composition, (2) led by a professional who is not necessarily a clinician, (3) operate 24/7, 365 days of the year, and (4) interact closely with service users and carers in the community, they provide important information and insights into the way in which other healthcare and social service systems might best be led.

The case studies provide an enormously rich source of data that enables an in-depth understanding of team development and functioning, based on detailed analysis of a wide range of relevant variables. In so doing, they provide both the academic and the practitioner with information, based on eight very different situations, that shows quite clearly the way in which a

range of contextual factors can affect performance and the achievement of agreed goals and targets. In this way, they offer strong messages for guiding best practice, in terms of (1) relationships with agencies external to the team, (2) the composition of teams, and (3) the kind of leadership that is optimally effective for teams to function effectively and to achieve their goals.

They also provide a very powerful message to those, at national and local level, who are in a position to formulate and implement policy in health and social care.

## **Limitations of the Study**

### **Small sample size**

The principal limitation of the study is the small sample of teams providing complete data. The reasons for the small sample size were twofold. The first reason was the inclusion criteria for participation in the study. While the national survey of CRHTs, which was conducted in parallel with this study, found approximately 240 teams in operation (Onyett *et al.*, 2006), many teams were excluded from our study that did not meet the core elements of the fidelity criteria outlined in the MHPIG (2001); also, in order to ensure that judgements made about the leadership of the team could be regarded as evidence based, only teams that had been in existence for six months or above were included. Hence, we had a maximum sampling frame of 120 teams.

The second reason for the small sample was the difficulty in collecting data from those teams that did agree to participate; these difficulties with data collection are explained below.

### *Responses to LCCL:*

The response rate of approximately 50 per cent is consistent with what would be expected from what was, in effect, a postal survey. Teams who agreed to participate, at least at the level of agreement by the team lead, varied considerably in their response rate. Visits to the teams undertaken by the researchers suggested that the reasons for this were not hard to find. It was evident that all the teams were very busy, and, additionally, that many were working under what may be regarded as sub-optimal conditions, from the point of view of the physical accommodation. Apart from any issues of time constraints on staff, it was not usually possible for the researchers, during their visits, to speak to more than the team lead and a small number of staff. This meant that it was not possible to explain, in detail, the nature and potential value of the research, or to engender interest in it; consequently, many staff may have had little interest in the project. It is also possible that the existence of two national projects in parallel – ours and the national survey referred to above – may have caused either confusion, or overload, or a combination of both.

In order to respond to initial evidence of a low response rate, the researchers pursued different methods to encourage increased participation. These included follow-up letters, telephone calls, and the initiation of a prize draw.

Since LCCI data were collected from the different teams during the period July 2004 to June 2005, it might be suggested that this would be a source of variation. In terms of intra-team differences, there was, however, no evidence to suggest that responses collected during 'round 1' of data collection differed from those collected at 'round 2'. Any differences attributable to inter-team differences relating to the age of the team were controlled for during the statistical analyses.

#### *Admissions data:*

A separate, but related issue was that of admissions data. Some teams did not have the information on admissions data to hand. This, while interesting in itself, might reflect a lack of integrated working with the psychiatric in-patient ward. This meant that these data were difficult to collect. In order to accommodate this difficulty, we attempted to obtain data from Hospital Episodes Statistics, through Dr Gyles Glover. This, however, proved difficult in terms of matching these data with the given names of the CRTs recruited to our study.

Our reliance on admissions data meant that the number of teams contributing to our analyses of team performance was depleted. There is no evidence to suggest that the teams that participated were in any sense unrepresentative of the population as a whole, but the size of the sample does impact on the generalisability of the findings.

#### **Use of hospital admissions data as main outcome measure**

It could be said that a second limitation of the study is the use of admission rates to psychiatric hospitals as a main outcome measure. However, it is relevant to point out that reducing admissions has been both a focus of government policy. It has also been used in evaluations to determine the effectiveness of a series of community-based mental health services introduced over the past decade, namely, Crisis Resolution Teams, Assertive Outreach and Intensive Case Management.

For CRTs, two key evaluations have utilised admissions to hospitals and the extent to which these are reduced. Glover *et al.* (2006), for example, using NHS routine admissions statistics, examined admissions for both Crisis Resolution and Assertive Outreach; they found trends to suggest reduced admissions since the implementation of both teams. Johnson and colleagues (2005a&b) in a before- and after-evaluation, and a randomised controlled trial of a CRT in North London, used admissions as their main outcome measure and found significant reductions. Similarly, a large scale randomised trial also used admissions to hospital as a primary outcome measure to assess the effectiveness of Intensive Case Management (ICM) – a community based mental health service working intensively with service users with severe mental health problems and reduced case load sizes (Burns *et al.*, 1999).



They, however, found no differences in admissions in ICM when compared to Standard Case Management. (One explanation of their findings concerns the few differences observed between ICM and standard care; the quality of the latter service was much higher than was initially understood.)

Use of admission rates as a measure of effectiveness is, therefore, not unusual, and indeed something targeted by government policy and research evaluations alike. However, the usefulness of admission rates as a main outcome measure is limited by the lack of available and accurate data. Routine statistics on admissions can be unreliable; gathering admissions data from patient's case notes can be equally problematic.

### **Approaches to change management**

The third limitation arose from the difficulty in obtaining quantitative data about team leaders' use of change models. The four team leads with whom the change management instrument was piloted did not encounter any difficulty, perhaps because they were able to ask questions of the researcher, face to face. However, when the instrument was distributed widely, even though it was used as the basis of an extensive one-to-one telephone interview, team leaders were unwilling or unable to provide the quantitative data that was being sought.

## **Implications of the Research**

### **Implications for Health Practitioners**

The importance of good quality leadership in any organisation cannot be emphasised enough. One of our key findings demonstrated this by revealing a significant relationship between good quality leadership and the effective functioning of a CRT. CRT staff involved in the case studies detailed their perceptions of good leadership and how their team lead supported their work and their own development. Having a visionary approach and engaging team members was seen as crucial to working successfully. These attributes aided a team lead to motivate staff. Many staff from the case study sites had a sense of purpose, and were clear about their role within the team. Staff motivation, however, was not solely related to good leadership. Many of the staff recruited to work in CRTs were already highly motivated and persuaded of the importance of this form of crisis service. In other words, staff who work in CRTs may – in common with others who work in areas that include health and social care – be a highly select group, comprising individuals who are both experienced practitioners, and who are wholly committed to the ethos of CRTs.

Good leadership, more specifically engaging with others, was also important in predicting positive staff attitudes towards work and well-being at work. The significance of this for practitioners includes the importance of feeling self-confident and having the ability to take decisions within in a well-defined structure. Other researchers have shown significant links between staff

attitudes and organisational performance (Patterson *et al.*, 2004; Xenikou & Simosi, 2005).

Certainly there are training implications for practitioners who, perhaps, feel less confident, or who lack the experience to make key decisions. Equally important, is the creation of a work environment in which staff feel empowered, are supported by their manager, have opportunities for development, and are highly motivated and satisfied with their job. The Onyett *et al.* (2006) national survey of CRTs asked teams to identify their top training needs. The four main categories identified included management support and leadership, although this priority came lower down team members' list than the highest priority which, unsurprisingly, related to developing more effective interventions and developing practice skills.

A further implication for practitioners derives from the concept of shared or 'distributed' leadership, and the acknowledgement that all team members play some part in the leadership culture of the team and its potential to operate successfully. Much of our understanding of this concept draws on the literature, which presents leadership training possibilities that do not just focus on one particular manager or leader, but on staff members generally. An innovative mental health service in Australia described how enabling clinicians to become leaders of 'quality' in their service through training has provided a useful framework for improved outcomes for patients and carers (O'Connor *et al.*, 2005). Effectively all staff, and not one person designated to ensuring 'quality', are 'handed' the responsibility for ensuring service quality which is designed to be embedded in everyday practice.

### **Implications for Managers**

Running a service well, having control over external influences and dealing with difficulties effectively, were key considerations for managers of CRTs. The relative prominence of the team lead appeared pivotal to a well functioning team, and demonstrates the importance of good leadership skills in this particular person. Team leads who are both experienced practitioners and managers emerged as crucial requirements for success. Some had postgraduate training and recognised many of the change management models listed in the analysing change questionnaire. Interestingly, many team leads who had undertaken post-graduate training did not always apply the models they had learnt, and found using a practical approach more useful. Some approaches included encouraging autonomy and good personal relationships during situations of change.

The impact of good leadership as identified by team members revealed how a supportive, visionary and a pragmatic approach to managing a CRT was highly effective in terms of maintaining good staff morale, developing a sense of purpose, having clarity of role, and creating good internal and external working relationships.

## Policy Implications and Implications for New Ways of Working

### *Implications for Leadership Development of Managers*

There is no doubt of the importance of promoting good quality leadership in mental health care and healthcare generally. Change is an inherent feature of health care services, and good leadership is essential for ensuring that it is well managed. CSIP/NIMHE (2007) recognises the need for effective leadership and leadership development to enable the 'New Ways of Working' in mental health a reality.

As such, policy makers need:

- (1) to recognise that managers need *practical* guidance in how to approach managing change.

Although when asked, managers were often able to cite models of change management, when it came to effecting some kind of change in a real-life situation, they tended to use their intuition;

- (2) Iles and Preece (2006) pointed to fundamental differences between 'leader development' and 'leadership development' when they noted that,

“Leader development refers to developing individual-level intrapersonal competencies and human capital (cognitive, emotional, and self-awareness skills for example), while leadership development refers to the development of collective leadership processes and social capital in the organization and beyond, involving relationships, networking, trust, and commitments, as well as an appreciation of the social and political context and its implications for leadership styles and actions.”

If there is one message that comes across strongly, both from the review of the literature, and the empirical findings, it is that an engaging style of leadership is crucial to achieving success. The implications of this include questioning whether leadership development programmes that rely exclusively on developing 'managerial/leadership competency' can be regarded as fully 'fit-for-purpose'.

- (2) Therefore, leadership development needs to focus on the kind of leadership development that goes beyond developing human capital, and addresses the issue of how best to develop social capital.

Leadership competencies can be effective in guiding leader development, and thereby increasing human capital, but an engaging style of leadership is what enables the release of human capital, and the creation of social capital.

Anita Roddick is quoted as saying that she wanted people with 'their head in the air, their feet on the ground, and their heart in the business'. These can be related, in the present study, to 'visionary' leadership, 'competent' leadership, and 'engaging' leadership. But, most importantly, if staff are to have high levels of job satisfaction, motivation and commitment, then they need to be fully engaged in what they do.

Leadership involves striving effectively towards a (shared) vision, but it also involves being supportive to staff in achieving that vision.

#### *Policy implementation and the introduction of new services*

Several other factors apart from good quality leadership influenced the success of the crisis resolution teams.

One theme to have emerged is that policies that are too prescriptive, as with the case of the MHPIG (2001), can ignore the local context and, as such, force teams to conform to a model that may not best fit their requirements. The example of CRTs highlights important issues around the formulation of policies and the introduction of new health services. Policy for the implementation of CRTs was very detailed and prescriptive, despite the limited availability of evidence of their effectiveness. Therefore, the implication for policy makers is that policy needs to describe the reasons for change and the desired outcomes, though very detailed methods for explaining how might be counter-productive.

The case studies underline the complexity of issues involved in the introduction and development of any new health services and, as such, revealed some of the salient issues that policy makers should consider when introducing a new service. Factors such as: - how a new service is received by relevant external agencies, and by the rest of the organisation in which the team is placed; the type of workforce recruited and the skills needed for a multidisciplinary team; interpersonal relationships between team members; funding issues; and the extent of senior management and Trust level support, are all key considerations in any policy initiatives to introduce new health services.

#### *Human resource considerations*

Related to the above, when introducing a new service, policy makers need to consider the best means by which to create positive attitudes among staff; generating a sense of purpose and ownership of their work and commitment to the people who use their services is an essential ingredient for success.

#### *Whole systems working*

'New Ways of Working' (CSIP/NIMHE, 2007) identified the benefits of integrating services and of having whole systems approach to service provision. Two of the case study teams had evolved beyond the MHPIG for CRTs by adopting an integrated approach to crisis care; these teams found this approach to be clivial to working successfully with other relevant

agencies. This whole system approach opens up further options to improving crisis care in mental health, and to the promotion of closer working relationships between services.

### *Performance targets*

Policy makers ought to reconsider the balance between achieving outcome or performance targets expected of mental health services, such as admissions to hospitals, as against focusing on staff and service user satisfaction and on other indicators of good quality crisis mental health care.

## **Conclusion**

### **Central messages to convey**

The first is that, as one leadership guru once observed, leadership is a 'contact sport', it is not a 'virtual reality'. Put in another way, one of a leader's principal roles is to engage actively and supportively with her/his staff and with others whom they work.

The evidence from this longitudinal study is that competent or 'capable' leadership, on its own, is not sufficient to achieve high levels of organisational performance; nor, on its own is 'visionary leadership'. What emerges as the key to success is *how* people are treated. This is *not* to say that competent or visionary behaviours are not relevant; rather, it is to suggest that quality of leadership is reflected in performing one's job *competently*, in a transformational or *engaging* way. Degree of engagement with others emerges as the best predictor, not just of staff attitudes and well-being, but also of organisational performance.

At the same time, contextual factors, both those that are intrinsic to teams, such as composition of, and relationships between, staff, and the nature of tasks undertaken, and those that are extrinsic, including social and political influences, can have a profound effect, not only on staff morale, but also on the achievement of desired outcomes.

The implications of this last statement include

- (1) that it is the responsibility of those in positions of influence to ensure, not just that leadership development is offered, but that what is offered is the kind of development that can be shown to engage staff, and to increase organisational performance;
- (2) that it is also the responsibility of those in positions of influence to ensure that designated staff be given the kind of human and material resources, and the kind of political and organisational support, that will enable them to perform their role effectively.

Comparison with evidence and current thinking, notably from the US, suggests that, in the UK, we have been able to provide a 'metric' of the kind

that can be used to assess the type of leadership that others see as being the most effective.

Although ten contextual factors that a review of the literature suggested would be relevant to achieving the goal were identified, the case studies led to the recognition of other relevant factors. Thus, the case studies led to a realisation

- (1) that factors such as relations between CRTs and the CMHT may have a significant effect on achieving goals,
- (2) that such factors may be so powerful as to neutralise, or even negate, the effect of leadership on performance.

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## **INTRODUCTION**

The *Ethical Leadership Culture and Change Inventory (LCCI)*© enables organisations, services, departments, and teams to gain information about their **culture** and **climate** with reference to both ‘**transformational**’ and **leadership competency** dimensions of leadership behaviour, qualities, skills and style.

Its emphasis is on providing diagnostic information that can guide change in directions that are

- more **ethical**
- more **effective**

## **COMPLETION GUIDELINES**

**Please take the time to read these instructions thoroughly.**

You have been asked to complete this questionnaire as part of a research project involving your team. Once all questionnaires have been completed and received by you and your colleagues, the results will be used to produce a report based on the responses.

Your responses will be combined with others who are taking part in the process, to form an overall average response to each item assess. Your individual responses will be **completely confidential**; the only person who will see the responses is the data analyst at LRDL who will feed the responses into the computer.

The questionnaire will take approximately 15 to 20 minutes to complete. It should be returned to LRDL in the FREEPOST envelope provided no later than the deadline specified by the LCCI© administrator in the team you are assessing.

## YOUR BIOGRAPHICAL DETAILS

NB: This information will be strictly confidential and will not be available to anyone outside the research team

Surname: \_\_\_\_\_

Forename/s: \_\_\_\_\_

Gender:                      Male                                            Female                     

Your age:                      25 or under                                            26-35                        
   36-45                                            46-55                        
   55 or over                     

You professional background: \_\_\_\_\_

Your position in the team (e.g. manager, team lead, clinical supervisor etc):  
\_\_\_\_\_

How long have you worked in your current organisation?

Less than 1 year                                            1-2 yrs                                            3-4 yrs                        
5-9 yrs                                            10+ yrs                     

Which of the following represents the highest level of education you have attained:

'O' Levels/GCSEs                                            'A' Levels                                            ONC                        
HNC/HND/BTEC/Cert HSM                                            1<sup>st</sup> Degree                                            Masters                        
Professional Qualifications                                            Doctoral qualification                        
(RMN, RGN, Dip, ILAM  
CQSW, CIPD)

What is your race or ethnic origin?

WHITE

British

Irish

Other  \_\_\_\_\_ (please specify)

**MIXED**

White and Black Caribbean

## Appendix 1: The *Leadership Culture and Change Inventory (LCCI)*©

White and Black African

White and Asian

Other mixed background  \_\_\_\_\_ (please specify)

### ASIAN OR ASIAN BRITISH

Indian

Pakistani

Bangladeshi

Other Asian background  \_\_\_\_\_ (please specify)

### BLACK OR BLACK BRITISH

Caribbean

African

Other Black background  \_\_\_\_\_ (please specify)

### CHINESE OR OTHER ETHNIC GROUP

Chinese

Other  \_\_\_\_\_ (Please specify)

## FURTHER INFORMATION

**It is important that the form be completed correctly. Please refer to the diagram below as to how the responses should be marked.**

*(insert diagram of how to respond to questionnaire)*

## THE QUESTIONNAIRE

**1 – Strongly Disagree**

**2 – Disagree**

**3 – Slightly Disagree**

**4 – Slightly Agree**

**5 – Agree**

**6 –Strongly Agree**

**D – Don't Know**

**N – Not Relevant**

**The culture of the team of which I am a member is characterised by:**

Item No.	Item
1	Being sensitive to staff's needs and aspirations
2	Striving to achieve goals and targets, within agreed time-scales and in accordance with standards and other criteria set
3	Involving team members in identifying the values by which the team will operate
4	Involving team members in the process of setting their objectives
5	Being able to analyse qualitative and quantitative data so as to make meaningful comparisons and/or to identify patterns and trends
6	A high level of self-esteem among staff
7	Being sensitive to the impact of decisions on members of the team
8	Being politically skilled in obtaining support from key players outside the team to achieve team goals
9	Showing consistent behaviour, rather than moodiness or unpredictability
10	Recognising the importance of maintaining staff morale
11	Understanding and using the team's overall strategy and purpose to achieve goals and objectives
12	Being strategic in its thinking
13	A strong sense of team effectiveness
14	Being prepared to take calculated risks in order to make things happen to achieve important outcomes
15	Setting agenda items and keeping meetings on course so that all members are encouraged and enabled to participate
16	Delegating tasks effectively based on knowledge of individual's competence or potential
17	Understanding and making effective use of the team's structures and systems, planning and decision making, to achieve goals
18	Using knowledge and understanding of what motivates staff to achieve
19	A high sense of fulfilment among staff
20	Ensuring that individuals are clear about the exact nature of their roles and responsibilities
21	Inspiring external stakeholders by its passion and determination
22	Communicating ideas in a clear and coherent way, modifying language and delivery to match individuals' needs
23	Undertaking consultations with all staff before taking decisions which affect them



## Appendix 1: The *Leadership Culture and Change Inventory (LCCI)*©

24	Encouraging all staff to think strategically rather than in the short term
25	Enabling all staff to feel valued members of the team by promoting a culture of inclusion
26	Having clear the boundaries for people's responsibilities
27	Ensuring that team members and others are clear about the nature of agreed activities, goals and/or targets, and the criteria for success
28	Involving appropriate staff when seeking solutions to problems
29	Taking a broad overview of the effect that change might have on different members of the team
30	Acting in a way that reflects a strong desire to identify and to meet the needs of users and carers
31	A high level of motivation to achieve
32	Allowing individuals to lead as and when the situation requires
33	Acting in a way that reflects a strong desire to identify and to meet the needs of team members
34	Keeping staff informed of what is going on in the team
35	Articulating clearly defined standards or criteria for staff to achieve
36	Providing individuals with good quality, constructive and timely feedback and guidance in relation to the performance of their job.
37	Regarding the good of the team as more important than satisfying personal ambition
38	Having clear vision of what the team is aiming for
39	Taking a broad managerial perspective of issues, rather than a narrow professional one
40	Being committed to the achievement and maintenance of high standards, constantly seeking improvements in service delivery and quality outcomes
41	Achieving a fair balance between caring for individual staff and meeting team objectives
42	Monitoring progress after delegation, in a supportive way
43	Gathering information about the availability of human and material resources, including attitudes and opinions of team members, users and carers, in a form that can be used for planning and decision making
44	Being decisive when required
45	Having staff who are approachable, rather than intimidating or status-conscious
46	A low level of job-related stress
47	Facing and dealing with conflict in a professional manner
48	Delegating specific tasks and/or decision-making authority in such a way as to make best use of individuals' time, abilities and/or potential.
49	Being sensitive to the agenda of a wide range of external stakeholders
50	Encouraging all members to think of wholly new approaches or solutions to problems
51	Undertaking developmental reviews in a way that is sensitive, constructive, and honest, and leads to the identification of mutually agreed developmental goals
52	Encouraging staff to develop by taking on increased responsibilities
53	Being team oriented to sharing crises, problem-solving, and decision-

## Appendix 1: The *Leadership Culture and Change Inventory (LCCI)*©

	making, when appropriate
54	Using knowledge and understanding of the team to determine what amount of change is feasible
55	Establishing, maintaining and updating procedures for ensuring quality
56	Being creative in thinking through various alternative solutions to problems
57	Staff who are motivated to achieve at a level beyond their own expectations
58	Drawing together people from a wide range of internal and external groups to develop ideas for achieving action
59	Establishing agreed standards of performance
60	Identifying clearly the core issues in complex problems/situations
61	Having staff who prefer to deal with people rather than systems
62	Communicating positive expectations of what its members can achieve
63	Managing the team's budget, based on accurate information and realistic projects
64	Clarifying priorities that staff need to focus on
65	Being honest and open in the way it acts
66	Being active in promoting inter-agency co-operation, by looking for, and actively pursuing, opportunities for collaboration towards common goals
67	Viewing dissent and criticism as valuable in improving the development of the team and/or the service provided
68	Involving all staff in developing the vision
69	Regarding values and principles as integral to the team's mission and mode of operation
70	A high level of job satisfaction
71	Being active in promoting inter-departmental co-operation, by looking for, and actively pursuing, opportunities for collaboration towards common goals
72	Sustaining individuals' efforts by demonstrating a genuine interest in them and what they do
73	Making sound judgements, based on a wide range of factual information, organisational values and constraints, and the views of team members, users and carers
74	Being able to think laterally/imaginatively
75	Involving internal stakeholders in developing the vision
76	Understanding the impact of implementing the vision on the different members of the team
77	Being able to handle situations involving conflict with sensitivity, attempting to understand the different points of view and to achieve shared goals
78	Trying to understand how all staff perceive things
79	Having good communication skills
80	Empowering staff by trusting them to take decisions or initiatives on important matters
81	A high level of self-confidence
82	Having effective mechanisms for promoting equality and diversity

## Appendix 1: The *Leadership Culture and Change Inventory (LCCI)*©

83	Tolerating the failings of others, when they can be seen to have tried to achieve
84	Being consistent in what it says and in what it does
85	Being able to manage time such that goals are achieved efficiently and effectively
86	Being effective in turning individuals' ideas into action
87	Making time for staff to discuss problems and issues, despite the busy schedule
88	Being committed to developing competent leadership at all levels
89	Ensuring that team members' and others' progress on delegated tasks is monitored effectively
90	A strong sense of commitment to their job
91	Being able to inspire all staff such that they want to contribute fully
92	Being active in supporting staff development through coaching and mentoring
93	Involving all staff in determining how to achieve the vision
94	Basing negotiations with team members, users and carers on well thought out arguments, which reflect an understanding of the other person's point of view
95	Being committed to bringing external stakeholders with them in pursuit of team goals
96	Trying to ensure that all staff are in agreement with the team's policies and procedures
97	Displaying a strong sense of loyalty and commitment to staff
98	Being willing to modify ideas after listening to staffs' or others' views
99	Maintaining a balance between the need to change and the need to maintain stability within the team
100	Having developed well thought out systems and procedures which support the effective use of resources
101	A strong sense of commitment to the organisation
102	Ensuring that staff at all levels are accessible
103	Maintaining stable performance under pressure, remaining calm, objective and in control
104	Encouraging feedback or constructive criticism of team performance or ideas for future action
105	Prioritising the critical goals and milestones for achieving team development
106	Articulating a vision for their team, in such a way that all staff can identify with it
107	Having staff at all levels who keep in touch with what is going on by walking around, talking and listening
108	Using face to face, rather than indirect communication, as and when appropriate
109	Planning projects on the basis of specified goals/targets and deadlines, and effective use of resources
110	Using power to facilitate rather than impose
111	A low level of job-related emotional exhaustion
112	Having staff at all levels who are prepared to stand up and be counted in supporting their colleagues

## **Appendix 1: The *Leadership Culture and Change Inventory (LCCI)*©**

113	Identifying long-term goals that are consistent with the vision of the team, specifying intermediate goals and possible contingency arrangements
114	Being prepared to modify decisions/courses of action as circumstance change, rather than being rigidly rule-bound
115	Being active in developing staff's strengths
116	Being active in promoting the work or achievements of the team to the outside world
117	Being active in promoting team working, by identifying others' interests, competencies and aspirations, and devising ways in which these can be developed to achieve mutually agreed goals
118	A strong sense of team spirit
119	Having staff at all levels who are good listeners

**Appendix 2: Analysing Change Questionnaire**

**ANALYSING CHANGE QUESTIONNAIRE**

(To be distributed to participants in advance, but completed by the researcher, either during a visit or by telephone)

<b>TEAM</b>	
<b>TEAM LEADER</b>	
<b>TELEPHONE NUMBER</b>	
<b>DATE OF CONTACT</b>	

## Appendix 2: Analysing Change Questionnaire

### SETTING UP A NEW TEAM

1a Have you set up a new team within the last 2 years?

1b If yes, were users and carers involved in the process?

YES	NO

If yes to Q1a, please briefly describe the stages you went through in doing so, including how you dealt with any **difficult issues** or **challenging situations**.

If yes to Q1b, please briefly describe what the process involved.

**Appendix 2: Analysing Change Questionnaire**

**CHANGE INVOLVING INTERNAL STAFF**

1c Has you team been involved in any **major** change or **significant** development over the last 2 years **involving staff**? For example,

- 1. introducing a wholly new system of operating
- 2. dealing with a situation involving personnel within the team?
- 3. moving to a new site?
- 4. other? –

YES	NO

If yes, please briefly describe (a) nature of the change(s)

(b) how you dealt with it/them.

## Appendix 2: Analysing Change Questionnaire

### CHANGE TO MANAGEMENT OR FUNCTIONING OF THE TEAM

1d Did the change referred to in Q1b involve a **major/significant** change to any aspect of the **management** or **functioning** of the **TEAM**? For example,

1. change of personnel **within** the team, e.g., team lead, psychiatrist, other senior staff?
2. appointment of staff?
3. addition of other **specialist skills**, such as, art therapist, OT, physiotherapist, social worker?
4. dealing with a situation involving **conflict within** the team?
5. dealing with a situation involving **conflict with other agencies**, such as, CMHT, GPs?
6. dealing with a change in funding arrangement?

YES	NO

If yes, please briefly describe (a) nature of the change(s)

(b) how you dealt with it/them.



**Appendix 2: Analysing Change Questionnaire**

**CHANGE INVOLVING EXTERNAL AGENTS**

2a Has you team been involved in any **major** change or **significant** development over the last 2 years **involving EXTERNAL AGENTS**? For example,

- 1. introducing a wholly new system of operating
- 2. developing a different kind of relationship with the CMHT
- 3. developing a different kind of relationship with GPs?
- 4. moving to a new site?
- 5. other?

YES	NO

If yes, please briefly describe (a) nature of the change(s)

(b) how you dealt with it/them.

## Appendix 2: Analysing Change Questionnaire

### CHANGE TO MANAGEMENT OR FUNCTIONING OF THE TEAM

2b Did the change referred to in Q2a involve a **major/significant** change to any aspect of the **management** or **functioning** of the **team**? For example,

1. change of personnel **within** the team?
2. addition of other **specialist skills**, such as, art therapist, OT, physiotherapist, social worker?
3. dealing with a situation involving conflict **within** the team?
4. dealing with a situation involving conflict **with other groups**, such as, CMHT, GPs, voluntary?
5. dealing with a change in **funding** arrangements?
6. user and/or carer involvement?
7. other?

YES	NO

If yes, please briefly describe (a) nature of the change(s)

(b) how you dealt with it/them.

## Appendix 2: Analysing Change Questionnaire

### PEOPLE THAT WERE INVOLVED WITH CHANGES

- 3 In relation to **each** of the changes or conflict referred to in Q1 and/or Q2, please indicate with whom the **changes** were mainly discussed:

Nature of change or conflict – Example 1:	
	Percent of time
<b>Only</b> with <b>SENIOR</b> staff in the team	
With <b>ALL</b> staff in the team	
With <b>USERS</b> and <b>CARERS</b>	
With <b>EXTERNAL</b> groups, e.g., CMHT, GPs, voluntary sector	
Other (please specify)	
<b>TOTAL</b>	<b>100 %</b>
Any comments about the <b>nature</b> of the <b>discussions</b> , e.g., the extent to which different individuals or groups were involved in the discussions; the kind of contributions they were able to make; difficulties encountered and how they were dealt with.	

## Appendix 2: Analysing Change Questionnaire

Nature of change or conflict – Example 2:	
	Percent of time
<b>Only</b> with <b>SENIOR</b> staff in the team	
With <b>ALL</b> staff in the team	
With <b>USERS</b> and <b>CARERS</b>	
With <b>EXTERNAL</b> groups, e.g., CMHT, GPs, voluntary sector	
Other (please specify)	
<b>TOTAL</b>	<b>100 %</b>
<p>Any comments about the <b>nature</b> of the <b>discussions</b>, e.g., the extent to which different individuals or groups were involved in the discussions; the kind of contributions they were able to make; difficulties encountered and how they were dealt with.</p>	

## Appendix 2: Analysing Change Questionnaire

Nature of change or conflict – Example 3:	
	Percent of time
<b>Only</b> with <b>SENIOR</b> staff in the team	
With <b>ALL</b> staff in the team	
With <b>USERS</b> and <b>CARERS</b>	
With <b>EXTERNAL</b> groups, e.g., CMHT, GPs, voluntary sector	
Other (please specify)	
<b>TOTAL</b>	<b>100 %</b>
<p>Any comments about the <b>nature</b> of the <b>discussions</b>, e.g., the extent to which different individuals or groups were involved in the discussions; the kind of contributions they were able to make; difficulties encountered and how they were dealt with.</p>	

## Appendix 2: Analysing Change Questionnaire

Nature of change or conflict – Example 4:	
	Percent of time
<b>Only</b> with <b>SENIOR</b> staff in the team	
With <b>ALL</b> staff in the team	
With <b>USERS</b> and <b>CARERS</b>	
With <b>EXTERNAL</b> groups, e.g., CMHT, GPs, voluntary sector	
Other (please specify)	
<b>TOTAL</b>	<b>100 %</b>
<p>Any comments about the <b>nature</b> of the <b>discussions</b>, e.g., the extent to which different individuals or groups were involved in the discussions; the kind of contributions they were able to make; difficulties encountered and how they were dealt with.</p>	

## Appendix 2: Analysing Change Questionnaire

### SENIOR MEMBER INVOLVEMENT IN TYPES OF CHANGE

- 4a Consider any **major changes** or **significant developments** that have taken place over the last 2 years that have been **initiated** or **led by you**.

When discussing these changes among **SENIOR members** of the team, what proportion of the time was devoted to the following kinds of change?

Type of change	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that takes place in an <b>incremental</b> way, which <ul style="list-style-type: none"> <li>is designed to <b>enhance</b> or <b>modify</b> the current functioning of the team; and</li> <li>often focuses on the <b>improvement</b> of a system or process, or of a skill or range of skills.</li> </ul>							
<b>Type of change</b>	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that involves three distinct phases, often referred to as: <b>unfreezing</b> the existing equilibrium within the team → <b>moving</b> to a new position → <b>refreezing</b> in a new equilibrium position.							
<b>Type of change</b>	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that involves <b>consulting senior staff</b> on a <b>regular basis</b> , and the long-term <b>self-development</b> of the <b>senior team</b> .							
<b>Type of change</b>	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that involves <b>consulting senior staff</b> on a <b>regular basis</b> , and the long-term <b>self-development</b> of the <b>whole team</b> .							
<b>Type of change</b>	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Other – please describe							
Any comments							

## Appendix 2: Analysing Change Questionnaire

### ALL TEAM MEMBERS INVOLVEMENT IN TYPES OF CHANGE

- 4b Consider the same **major changes** or **significant developments** that have taken place over the last 2 years that have been **initiated** or **led by you**.

When discussing these changes among **ALL members** of the team, what proportion of the time was devoted to the following kinds of change?

Type of change	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that takes place in an <b>incremental</b> way, which <ul style="list-style-type: none"> <li>is designed to <b>enhance</b> or <b>modify</b> the current functioning of the team; and</li> <li>often focuses on the <b>improvement</b> of a system or process, or of a skill or range of skills.</li> </ul>							
Type of change	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that involves three distinct phases, often referred to as: <b>unfreezing</b> the existing equilibrium within the team → <b>moving</b> to a new position → <b>refreezing</b> in a new equilibrium position.							
Type of change	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Change that involves <b>consulting all staff</b> on a <b>regular basis</b> , and the long-term <b>self-development</b> of the <b>whole team</b> .							
Type of change	None	1/6 <sup>th</sup>	1/3 <sup>rd</sup>	1/2	2/3 <sup>rd</sup>	5/6 <sup>th</sup>	All
Other – please describe							
Any comments							



**Appendix 2: Analysing Change Questionnaire**

**MODELS USED WHEN IMPLEMENTING CHANGES**

5 When implementing these changes or developments, with **either** senior staff, **or** all staff, were you conscious of using any of the following approaches, models or techniques?

**Weisbord’s Six Box Organisational Model**, which identifies six areas for success: Leadership, Purpose, Relationships, Structure, Helpful mechanisms, Rewards.

**The 7S Model**, which suggests the need for harmonisation between: Shared Values, Strategy, Skills, Staff, Style, Systems, Structure.

**PESTELI**, which provides a checklist in the following areas: Political factors, Economic influence, Sociological trends, Technical innovations, Ecological factors, Legislative requirements, Industry analysis.

**Five Whys**, which is a technique for addressing single-problem events, through a series of 5 questions: Why did this happen? Why is that? etc.

**Content, Context and Process Model**, which suggests that there are five inter-related factors that are important in shaping performance: Environmental assessment, Human resources, Linking strategic and operational change, Leading change, Overall coherence.

**Soft Systems Methodology**, which involves: Finding out about a problem situation and its causes, Articulating ‘root definitions’, Debating the situation, Taking action.

**Process Modelling**, which is used to gain clarification of different views and expectations of a process by presenting as a Process Flow Map, in which all the different stages are mapped in sequence.

**Influence Diagram**, which expresses inter-relationships between different parts of a system, in terms of the influence of one element on others.

**Theory of Constraints**, which suggests that the efficiency of any multi-phase process is determined by the slowest step, and that systems should be analysed, and bottlenecks identified and addressed.

**NHS Modernisation Agency** 10 High Impact Changes for Service Improvement and Delivery

**NIMH** Model for implementing change

**Other Model** – please specify.

YES	NO

**Appendix 2: Analysing Change Questionnaire**

If yes to any approach, model or technique in Q5, please comment briefly on **how you and your team used it** (or them):

<p>What, <b>in your experience</b>, are its/their particular <b>strengths</b>?</p>	<p>What, <b>in your experience</b>, are its/their particular <b>weaknesses</b>?</p>

**Appendix 2: Analysing Change Questionnaire**

**TECHNIQUES USED WHEN IMPLEMENTING CHANGES**

6 Also, when implementing these changes or developments, with **either** senior staff, **or** all staff, were you conscious of using any of the following approaches, models or techniques?

**SWOT analysis** – analysis of Strengths, Weaknesses, Opportunities, Threats, as a stimulus to change and guidance as to what action to take.

**Force Field analysis** – identifying Driving forces that push in a certain direction, and which tend to initiate or maintain change; and Restraining forces that restrain or oppose them.

**Sources and potency of forces** – analyses ‘sources of change’ such as Owners, Legislature, Employees, Trade Unions, and Social Values in terms of their potency, and also ‘readiness and capability’ for change of individuals and groups to enact change.

**Readiness and capability** – understanding ‘readiness’ involves analysing attitudes, willingness, motives, and aims; ‘capability’ is determined by whether there is the power, influence, and authority to allocate resources.

**Commitment, enrolment and compliance** – when change is imposed externally, it unlikely to succeed unless some of those involved favour it. Different degrees of compliance/non-compliance are: - Commitment, Enrolment, Genuine compliance, Formal compliance, Grudging compliance, Non-compliance, Apathy.

**Total Quality Management (TQM)** – the four underling themes are: - organisational success depends on all department meeting external and internal customer demands; quality is an effect caused by the production process, most human beings are intrinsically motivated, simple statistical methods and data analysis can provide powerful insights.

**Business process re-engineering (BPR)** – the underpinning concepts are: - organisations should be organised around key processes, multi-skilled working should replace narrow specialism, radical re-thinking should be disassociated from current practices; the direction for radical re-thinking comes from top management.

**Parallel learning structures** – typically comprising a steering committee and a number of working groups, they can help people undertake genuine enquiry and initiate change, by breaking free of organisational constraints.

**Self-managing teams** – such teams are responsible and collectively accountable for performance and monitoring, and for managing inter-personal processes.

**Innovative research** – involves five stages: - establishing awareness, persuasion, mental evaluation, trial, and implementation.

**Securing individual behaviour change** – interventions include: - dissemination of educational materials, educational outreach, local opinion leader, audit and feedback, reminders, continuing education, dissemination of guidelines.

**Other** – please specify

YES	NO

**Appendix 2: Analysing Change Questionnaire**

If yes to any approach, model or technique in Q6, please comment briefly on **how you and your team used it** (or them):

<p>What, <b>in your experience</b>, are its/their particular <b>strengths</b>?</p>	<p>What, <b>in your experience</b>, are its/their particular <b>weaknesses</b>?</p>

Thank you very much for your help.

## Appendix 3: Case Study Topic Guide

### CRT Case Study Topic Guide

#### Aims and goals

- What are the main aims and goals of the team?
- Is there a sense of shared aims/goals amongst the team?
- How are the aims and goals communicated/permeated throughout the team?
- What are the barriers to fulfilling these goals (internal to the team/external to the team)?
- What aids the fulfilment of these aims/goals?
- Are you clear about your role & function within the team?

#### Leadership

- What does good leadership mean to you?
- What would you see as the key issues around effective leadership?
- How does this translate into practice?
- How does this compare with the leadership in your team?
- How would you describe the style of leadership your leader has?
- What are the strengths/weaknesses of your leader?
- Can you give examples of times when you think your leader has been effective /ineffective?
- Are leadership issues agreed /defined: (responsibilities, authority and accountability)?
- Do you have consistency of structure and processes?
- What leadership processes are in place?
- Do you come across resistance to change at the organisational or individual level?

#### Team

- What are the strengths of the team?
- What are the weaknesses of the team?
- What are relationships like within the team?
- What are your relationships like with external agencies (CMHT, voluntary sector, A&E, GPs etc.)?
  - Are there systems in place to make this work effectively?

#### Admissions & Referrals

- How are patients admitted to hospital?
  - What is the role of the CRT in this?
  - What are the underlying pressures that affect gate keeping role?
- What are the most important influences on admissions (anything beyond clinical need)?
- What are the alternatives to inpatient care available in the area?
- How are referrals dealt with, filtered or selected for relevance! Who decides this?

## Appendix 3: Case Study Topic Guide

### Finally....

- What do you believe makes an effective CRT?
- How do you think this effectiveness should be measured?
- Do you feel your team is effective?

## Appendix 4: Hierarchical Multiple Regression

Hierarchical multiple regression analyses for facet scores for 'job satisfaction', 'motivation to achieve', 'motivation to achieve beyond expectations', 'job commitment', 'organisational commitment', and 'reduced stress', against Contextual variables, and Scale 1, Scale 2, or Scale 3 (beta values).

VARIABLES	Job satisfaction	Motivation to achieve	Motivation to achieve beyond expectations	Job commitment	Organisational commitment	Reduced stress
Psychosis	.05	-.05	-.07	-.06	-.05	-.09
MINI	-.02	-.00	-.05	-.02	.05	-.04
Alternatives	.01	-.01	-.05	.03	-.03	.04
Team age	-.01	-.05	-.09	-.06	-.06	-.02
Staff/case	.02	-.04	-.06	.02	.00	.08
Gate-keeping	.05	.04	.03	.08	.02	.15*
Medical cover	-.08	-.09	-.08	-.04	-.09	-.15*
Multi-disciplinary	-.04	-.04	-.04	.03	-.03	-.04
Service cover	-.03	-.03	.01	-.05	-.03	-.08
Scale 1	.68***	.68***	.63***	.63***	.52***	.39***

\* –  $p \leq .05$     \*\* –  $p \leq .01$     \*\*\* –  $p \leq .001$

## Appendix 4: Hierarchical Multiple Regression

VARIABLES	Job satisfaction	Motivation to achieve	Motivation to achieve beyond expectations	Job commitment	Organisational commitment	Reduced stress
Psychosis	.11	.01	-.01	-.01	-.00	-.06
MINI	-.02	-.00	-.05	-.01	.05	-.05
Alternatives	.02	-.01	-.05	.04	-.03	.04
Team age	.02	-.03	-.07	-.03	-.04	-.01
Staff/case	.05	-.01	-.03	.04	.02	.10
Gate-keeping	.05	.04	.03	.08	.02	.15**
Medical cover	-.03	-.05	-.04	-.01	-.05	-.12*
Multi-disciplinary	-.04	-.03	-.04	-.02	-.02	-.03
Service cover	-.09	-.04	-.04	-.07	-.07	-.12*
Scale 2	.61***	.63***	.55***	.50***	.49***	.42***

\* –  $p \leq .05$     \*\* –  $p \leq .01$     \*\*\* –  $p \leq .001$



#### Appendix 4: Hierarchical Multiple Regression

VARIABLES	Job satisfaction	Motivation to achieve	Motivation to achieve beyond expectations	Job commitment	Organisational commitment	Reduced stress
Psychosis	.12	.02	-.01	-.00	.00	-.05
MINI	-.01	.01	-.04	-.01	.06	-.04
Alternatives	.03	.01	-.04	.05	-.02	.05
Team age	.05	.00	-.04	-.01	-.01	.01
Staff/case	.05	-.01	-.03	.05	.02	.10
Gate-keeping	.03	.01	.00	.06	.00	.13*
Medical cover	-.02	-.03	-.02	.00	-.04	-.12
Multi-disciplinary	-.04	-.03	-.03	.03	-.02	.04
Service cover	-.08	-.03	-.03	-.09	-.07	-.11*
Scale 3	.64***	.67***	.63***	.59***	.51***	.40***

\* –  $p \leq .05$     \*\* –  $p \leq .01$     \*\*\* –  $p \leq .001$

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