The evaluation of a local whole systems intervention for improved team working and leadership in mental health services

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Abstract

Fourteen mental health teams covering community, inpatient, and primary care across different NHS regions in England completed the pilot stage of the evaluation of a seven-day focused local whole systems intervention for improved teamworking and leadership. Outcome at the end of the programme was evaluated using measures of teamwork, team effectiveness, staff burnout, job satisfaction and leadership style. Team working improved significantly across the sample in terms of communication, support for innovation, clarity of objectives and focus on quality. Although changes were in the desired direction for all the other outcome measures they did not reach statistical significance. Exploring changes for teams as a whole, perceptions of team working improved from the start to the finish of the programme in 13 teams. Participant feedback from session to session of the programme was positive. Action learning sets, user involvement, improved communication and small group discussions were particularly well received. Ratings of the delivery of the programme were also high across all 14 programmes. The study provides pointers for the development of whole systems interventions in this key area of local service improvement.

The evaluation of a local whole systems intervention for improved teamworking and leadership in mental health services

Introduction

It seems widely acknowledged that in light of an "ever-tightening financial situation.. more will have to be achieved through service redesign rather than increased capacity" (McLellan, 2005, p.3). Since the turn of the century there has been dedicated improvement support to achieve such redesign in mental health services, for example through the National Institute for Mental Health in England (NIMHE). Much has been achieved through improvement work aimed at improving the process and experience of care (as required by standard five of the National Service Framework for Mental Health; Department of Health, 1999), and multiple sources of support for leadership development. However, despite an explosion of publications on leadership "…so far, 40 years of NHS management training has not done much to improve service delivery" (Millward & Bryan, 2005, xx). There is a complex and often poorly coordinated market of leadership development support for practitioners to navigate (Millward & Bryan, 2005; Edmonstone & Western, 2002).

Reviews of the leadership literature increasingly conceptualise leadership as an emergent process that occurs in the productive quest for specific outcomes; "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2004, p.3). This dispersed model of leadership is also endorsed by policy, for example in the Darzi review (Department of Health, 2008) of the English National Health Service (NHS) with its expectation that ever practitioner will be a clinician, partner and leader..

Dispersed formulations of leadership need to be mirrored in leadership development initiatives. In the early days of the NHS Leadership Centre, Goodwin (2000) advocated a move away from a focus on individual skill development towards a "local leadership mindset". He advocated that leadership development should be mandatory, locally focussed, based around action-learning principles, and concentrated on inter-organisational and shared leadership between organisations rather than leader-follower relationships within organisations.

Despite the complex and diverse market of improvement resources, development support that integrates improvement science and leadership development through dedicated local whole systems interventions remains unusual. Similarly while there exists widespread recognition of the dispersed nature of leadership within complex health and social care systems (e.g. Bolden, 2004) the essential team-based nature of provision is comparatively rarely recognised in improvement interventions. This is particularly problematic in light of the consistent finding of the Healthcare Commission's (2008) NHS National Staff Survey on teamworking. The latest revealed that 93% of staff responded positively when asked: "Do you work in a team?" but that this shrunk to only 42% when the survey explored whether the team in question fulfilled criteria for a well structured team: clear objectives, close working with other team members to achieve these objectives, regular meetings to discuss effectiveness and how it could be improved, and no more than 15 members. These findings have been consistent every year since 2003 and are of considerable import given findings that "pseudo" teams that are teams in name alone achieve outcomes that are often worse than not working in a team at all (West & Spendlove, 2005).

With funding from the Leadership Centre (part of the then Modernisation Agency) two of the authors (SO & CB) developed the "Effective team working and leadership in mental health" (ETL) programme. Its development was influenced by some key observations:

1. Leadership initiatives sometime fail to focus strongly enough on service improvement and service improvement initiatives often fail to take enough account of the involvement of senior managers (Onyett, 2006). Hence the need to integrate the two at local level. The programme included exposure to the Modernisation Agency's most widely used approaches to improvement such as process mapping and plan-do-study-act cycles that have a recognised evidence-base (McLeod, 2005; McNulty & Ferlie, 2002).

2. Leadership is bound by context, shaped by the task in hand and dispersed (Bolden, 2004). Effective leadership can only be judged by results. In other words *successful leadership is about creating an environment that supports individual team members in being maximally effective in achieving those outcomes that are valued by users and their supporters*. Creating that environment is the job of everyone in the team, although key individuals will have particularly roles in achieving, maintaining and improving the environment over time. Issues of leadership were therefore explored with all participants rather than just those in formal leadership roles.

3. The vast majority of care is delivered by teams and this is where service improvement and effective leadership needs to be enacted (Healthcare Commission, 2008). The programme development was informed by findings on the effectiveness of health care teams (Borrill *et al*, 2000) and a review of leadership and team working in mental health (Onyett, 2003, 2007). It is not surprising, though rarely acknowledged, that factors underpinning effective leadership and management (Alimo-Metcalfe and Alban Metcalfe, 2005) coincides strongly with those associated with effective team working and innovation (West et al, 1998; Borrill *et al*, 2000).

4. It cannot be assumed that the ways teams are currently configured are real teams in the sense that they are the people who most need to work together to achieve improvement for a specific group of service users. The programme was therefore designed for a maximum of 21 participants who were interdependent on each other to achieve positive outcomes for a specific group of service users. Such interdependence is a key criteria for effective teamworking (Onyett et al, 2007).

5. In trying to engage practitioners in change it makes sense to use evidence-based models of change that they are familiar with from their clinical work. For example it used a solutions focussed approach to clarify objectives (Jackson and McKergow, 2002) and motivational interviewing to engage the involvement of stakeholders (Rollnick, 1999).

6. Sustainable teamworking and improvement requires that we also consider the mental health of staff, and so this was the focus of the final day of the programme.

Table 1. Outline contents of the ETL programme.

Day one	❑ Listening to users and their supports give their account of what it is like to experience local services. ❑ Developing a shared vision of an effective local service. ❑ Hearing managers and strategists talk about the role of local teams and their inter-relationships. ❑ Exploring leadership both as a leader and a follower.
Day two	❑ Describing, clarifying and agreeing the values that underpin the work of the teams. ❑ Evaluating team climate, and using this to inform the team's development needs. ❑ Individual planning of change projects.
Day three	❑ Understanding each other's roles more clearly. ❑ Learning how to support each other more effectively through peer coaching. ❑ Supported self-reflection on participant's roles as leaders and team members.
Day four	❑ Understanding the complex systems in which participants work and how to achieve meaningful and sustained improvement. This includes exploring some widely used tools for improvement, such as process redesign, plan-do-study-act cycles and outcome measurement.
Day five	❑ Improving communication in the team by reviewing the effectiveness of meetings, how information is exchanged and how participation in decision-making can be increased.
Day six	❑ Clarifying issues of responsibility and accountability within the team and how decisions are made. This includes participants getting to grips with difficult issues concerning the exercise of power within teams, and their own authority.
Day seven	❑ Exploring how the team can continue to improve over the long term, including a focus on maintaining the mental health of team members.

The programme was delivered over seven days with the first two days close together and the others spaced out over three week intervals. Research on teams (e.g. Borrill et al, 2000) highlights that clarity of objectives is the sine qua non of effective team working. The initial days therefore focused on clarifying the aims and values of the service by getting both a strategic view from senior managers, and service users and their supports (e.g. friends and family) telling stories of their lived experience of the service as it is. From day three participants spent the afternoons in action learning sets pursuing agreed personal objectives informed by the earlier objective setting work. Participants received considerable preparation on how to work effectively in learning sets. The programme was configured to contain both core and optional components, to be included depending on needs as defined by participants in the early stages of the programme and in pre-programme planning with senior managers. A full outline of the programme is given in Table 1.

The Leadership Centre funded regional coordinator posts within NIMHE development centres, a train-the-trainers process and support for implementation. In this pilot phase it was implemented in services for adults and older adults with mental health problems, prison in-reach and prison staff, low secure provision, local implementation teams and zero-rated trusts

through the Clinical Governance Support Team. The Leadership Centre adapted the programme for implementation in cancer services and ambulance trusts. It has subsequently been rolled out through NIMHE (now within the Care Services Improvement Partnership; CSIP) development centres with interest expressed in expanding it to other care groups (e.g. in-patient care, children and family services, early intervention, and learning difficulties) and to executive teams.

Methods

Procedure

Teams were recruited through briefings, the establishment of regional coordinator roles and existing liaison roles within regional NIMHE development centres. Regional coordinators acted as a point of contact for teams, briefed local health and social care communities on the programme and coordinated practical aspects of implementation such as organising venues and materials, and developing local capacity (e.g. through "Train the trainers" events) to run local programmes. They often took a lead role in delivering programmes.

Once teams had signed up to attend the development programme, regional co-ordinators informed the evaluation team of names of participants, the programme start date, and where possible all planned further dates. Evaluation packs were forwarded to co-ordinators or facilitators ready for completion on Day 1 of the programme. When Day 7 was due, post-programme evaluation packs were again forwarded to co-ordinators. Bespoke feedback reports were produced for each team completing.

The intention was to repeat measures at six months after the completion of the programme to explore the sustainability of change. However, the organisational turbulence over the period of the study within the NHS was such that it proved impossible to locate and evaluate the teams forming the original sample with the exception of two teams.

Sample

Twenty mental health teams participated in the pilot stage of the evaluation, comprising 327 individual mental health practitioners. Of the 20 teams, 14 completed the post-programme evaluation procedure, and are therefore included in the analysis, reducing the overall sample to 230 practitioners. Of the six teams not completing the post evaluation, three were not provided locally with evaluation questionnaires (two inpatient mental health teams and one CMHT); and three dropped out of the development programme while it was in progress (one prison mental health team; two CMHTs). The 14 completing teams were distributed across England over the following regions: South West [8 teams]; London [3 teams]; East Midlands [1 team]; and the South East [2 teams]. The programme covered Community [9 teams], prison in-reach [2 teams] and local implementation teams associated with specific primary care trusts [3 teams]. Post-programme evaluation questionnaires were returned by 159 mental health practitioners in the 14 completing teams. Table 2 describes practitioners' professional disciplines. The 'other' category in Table 2 included, for example, managers/operations managers across the locality, team managers, nurse consultants and prison service managers.

Table 2: Participants' disciplines

	N	Percent
Community Mental Health Nurse	43	19.5
Other nurse	37	16.7
Social work	25	11.3
OT	19	8.6
Consultant psychiatrist	8	3.6
doctor (other than consultant)	8	3.6
Generic MH worker	19	8.6
Clinical psychologist	8	3.6
Other specialist therapist	6	2.7
Admin	21	9.5
Voluntary	1	.5
"Other"	26	11.8

Measures

Two main methods of data collection were used: (1) before and after evaluation of team working, team effectiveness, staff burnout, job satisfaction and leadership style using a composite questionnaire (the Team Member Questionnaire: TMQ); and (2) the session feedback questionnaire, which was completed by participants at each session.

Team member Questionnaire (TMQ)

The TMQ was based on several pre-existing instruments including the Team Climate Inventory (TCI: Anderson and West, 1996); Leadership Style (West and Markiewicz, 2004) items; the Job Satisfaction scale (Mullarkey et al., 1999); the Maslach Burnout Inventory (Maslach and Jackson, 1996); and the Community Mental Health Team Effectiveness Questionnaire (CMHTEQ: Rees et al., 2001).

(a) The TCI

The TCI, is composed of four scales measuring communication within the team, the level of support for innovation, the clarity of team objectives and the focus on quality. The baseline ratings were used for feedback on team working during Day 2 of the development programme.

(b) Leadership Style

This was a 14-item scale derived from leadership style research across organisations and occupations (West & Markiewicz, 2004). The scale is made up of leadership behaviours such as, for example, being accessible to team members, helping the team to acquire the resources needed to carry out work, and expressing confidence in team members' ability to carry out their work. Reliability analysis showed that the best scale combined all 14 items (standardised item alpha .96).

(c) Job Satisfaction

The 15-item job satisfaction measure used in the TMQ was developed by Warr, Cook and Wall (1979), and manualised by Mullarkey et al. (1999), as a robust instrument easily completed by staff at all levels. It is a 7-point Likert-type scale. For this analysis, it was scored to provide an index of overall job satisfaction.

(d) Maslach Burnout Inventory

The 22-item Maslach Burnout Inventory (Maslach et al, 1996) explored (a) emotional exhaustion, where emotional resources are depleted; (b) depersonalisation, the development of negative, cynical attitudes towards clients; and (c) a reduced sense of personal accomplishment.

(e) The CMHTEQ

This section examines team members' perceptions of the extent to which their teams are effective in three domains: meeting external requirements; processes within the team; and the use of evidence and feedback. The 27 criteria of effective practice which make up this measure were developed using the constituency approach, which acknowledges and indeed capitalises on the differences among stakeholders, and takes all perspectives into account. It was developed using a stakeholder workshop approach involving users, carers, advocates, practitioners, mental health researchers, policy makers and managers (Rees et al, 2001; Richards & Rees, 1998).

Session feedback questionnaire

On each day of the programme, participants completed a short questionnaire relating to the day's specific components, as set out in the programme's training manual. They rated each component in terms of its relevance or usefulness, and how well that component was delivered. All participants were also invited to comment on what was best about the day's training, what was least satisfactory, and what advice they would give about running the day again.

Results

Analysis was carried out at (a) the individual level, to look at change over time for the whole sample collectively and to compare across professions; and (b) at the team level. As this was a whole-team development programme it was important that the individual level analysis did not eclipse findings concerning the differing experience of participating teams.

Change over time on the TMQ

Individual level analysis for the whole sample

There is an important proviso in considering change scores, as numbers completing the TMQ dropped from 230 at the start to 159 at the end. For the results presented here, a second analysis was carried out to make sure that those returning post questionnaires did not skew the data, in that they may have been more positive to begin with. Therefore the baseline analysis was repeated including only the group returning the post-programme TMQ. There were no significant differences in the findings revealed by the two analyses.

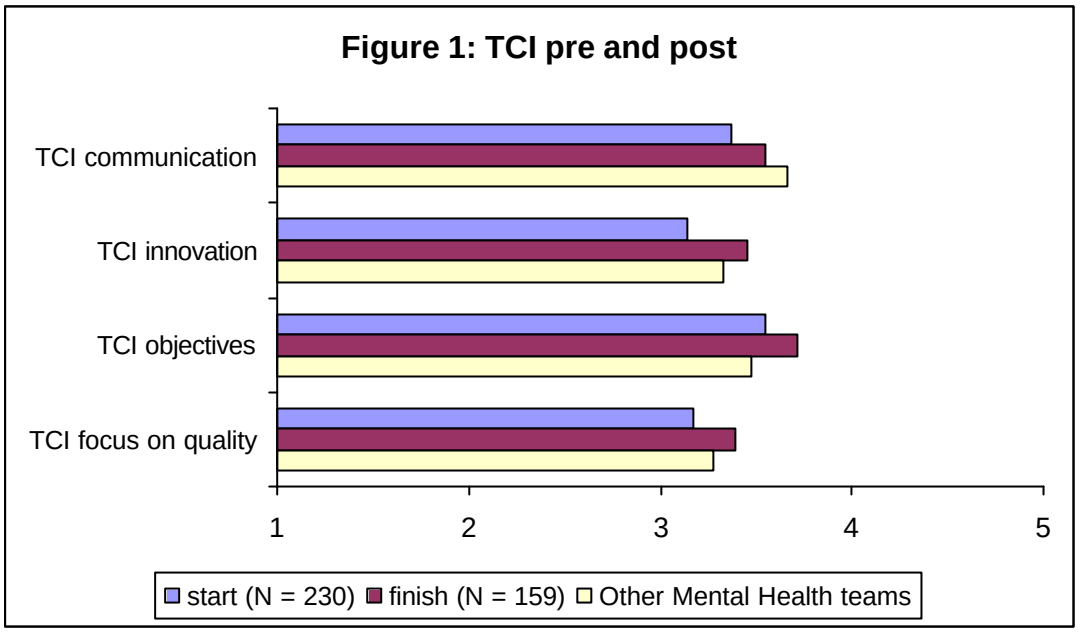
Table 3: Paired t-tests on all TMQ scales

	T1 Mean(SD)	T2 Mean(SD)	ES*	t	Df	*p*
TCI communication	3.38(.62)	3.51(.64)	0.21	-2.037	125	.044
TCI innovation	3.16(.63)	3.40(.58)	0.46	-3.796	124	.000
TCI objectives	3.53(.58)	3.67(.59)	0.24	-2.422	122	.017
TCI focus on quality	3.16(.76)	3.34(.69)	0.26	-2.529	125	.013
Leadership style	3.68(.80)	3.63(.92)	0.06	.682	123	.496
Job satisfaction	4.89(.95)	4.78(.85)	0.12	1.300	123	.196
Maslach personal accomplishment	35.51(6.07)	35.12(7.27)	0.06	.587	122	.558
Maslach emotional exhaustion	20.10(9.70)	19.07(9.65)	0.11	1.362	124	.176
Maslach depersonalization	5.11(4.81)	4.30(3.99)	0.18	1.966	124	.052
CMHTEQ external requirements	3.60(.60)	3.69(.55)	0.16	-1.460	119	.147
CMHTEQ team process	3.49(.64)	3.54(.62)	0.08	-.826	120	.410
CMHTEQ evidence and feedback	3.27(.73)	3.38(.67)	0.16	-1.466	117	.145

* All reported effect sizes were calculated as Cohen's d, with the post-programme mean subtracted from the pre-programme mean, and the pooled SD of both timepoints as the denominator. The level of the effect size is assumed using Cohen's d (1977) criteria as: .20 is small; .50 is medium; and .80 is large.

Table 3 presents TMQ scale means and standard deviations at the two time points, together with t and p values. Although effect sizes are small, paired t-tests reveal that overall team participants' perceptions of their functioning improved significantly over time on all aspects of team working as measured by the TCI. However, although in the desired direction, changes in leadership style, job satisfaction, burnout and effectiveness failed to reach significance.

Figure 1 shows initial and final scores across the sample, compared with the normative data of 113 CMHTs collected in a previous study (Borrill et al, 2000). Participants rated their team functioning lower than other CMHTs on each dimension of the TCI at the start of their courses. However, Figure 1 also shows that for those completing the post-programme TCI, perceptions of team performance improved over time, and on three aspects, had moved higher than the normative sample.

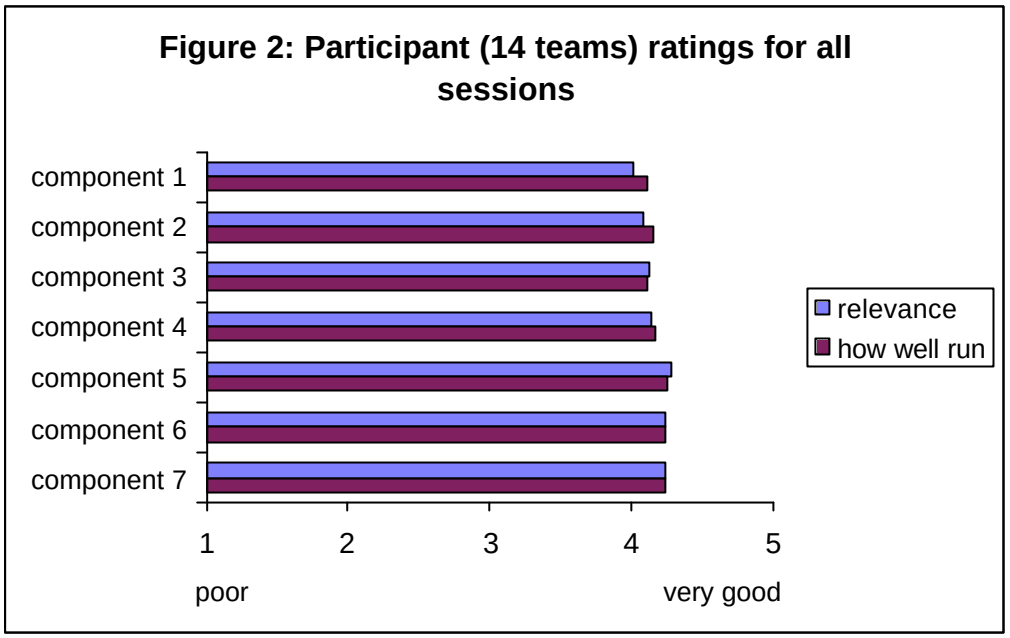


On the Maslach Burnout Inventory, thresholds have been set according to norms in mental health work, generated from a sample of 730 mental health practitioners. No significant change was apparent in our sample. The majority of participants in the programme registered a positive, high level of personal accomplishment, both at the start and end of the programme.

Analysis of variance was used to test differences over time for the different disciplines on all TMQ scales. Overall, the group of generic mental health workers were different from all other groups, in that scores deteriorated over time; for other groups scores improved from the beginning to the end of the course. The difference was statistically significant for support for innovation dimension of team working (df 6,110) $F = 2.63$, $p = .020$, and all dimensions of the CMHTEQ: external requirements (df 6,110) $F = 3.14$, $p = .007$; team processes (df 6,110) $F = 2.54$, $p = .024$; and evidence and feedback (df 6,110) $F = 3.35$, $p = .005$). No inter-disciplinary differences were apparent on levels of burnout, leadership style or job satisfaction.

Session feedback: overall

Figure 2 presents overall participant session feedback results across all 14 teams and 7 days of the programme. All ratings, both in terms of the relevance of components and how well the day was run, were above 4, or between 'good' and 'very good'.



Comments indicated that participants valued the opportunity to interact with other team members away from the work environment. They enjoyed both networking and the chance to meet new people, and find out more about them. In every programme, practitioners felt they had benefited from the honest input from users and carers.

The quality of facilitation was much appreciated. Participants found facilitators enthusiastic, motivated, proactive, responsive and supportive. The style of facilitation created a relaxed atmosphere where people could be open, honest and involved. This appeared to overcome the issue some raised relating to a difficulty with being critical or negative when sharing training with their team manager.

Team level analysis

The ratings of the majority of the 14 teams improved from the start to the end of the development programme. Tables 4a to 4c show within-team change on all TMQ scales. The mean score is the actual change from start to end. For all scales except MBI emotional exhaustion and depersonalisation, a minus score represents a positive shift.

Not all teams made significant improvements. One (team 7) showed deterioration on all scales, and one a downward shift on some scales (team 1). One team (14) improved on all TMQ scales. In exploring these contrasting team experiences in more detail it is clear that team 14 described day-to-day session feedback that was overwhelmingly positive with most negative comments related to the venue. At day 1, individuals felt they were beginning to be one team, and work more effectively together as a team. Team members appreciated the level of facilitation, and thought that overall the day had a very positive felt. This pattern continued throughout the programme. On day 7, the discussion around boosting morale generated most positive comment. Pre-programme discussion within this team had highlighted concern over conflict. As predicted, conflict had arisen during development sessions but it was perceived as having been well handled, and participants were more confident that they would have better ways of dealing with conflict and other team issues as a result of the programme.

In contrast team 7 with deteriorating scores started with the overall aim being to build practitioners into a newly formed team in a context where no psychiatrists or social workers

were involved. At day 1, some participants found the TMQ not relevant, as they had not been together in a team. Despite these structural problems with the team positive comments outweighed the negative in session to session feedback. At day 1, individuals were excited about the opportunity to meet other team members, so the initial introductory session was important, and experienced positively. This pattern continued throughout the programme. At day 7, the discussion around boosting morale also generated most positive comment, although some disappointment was expressed relating to the delayed opening of the unit where the team was to be based. This meant that the impetus generated by the programme would be lost.

Discussion

The changes on the feedback scales are outlined in Table 4 at the end of the paper. The TCI scales (Table 4a) which were used for feedback to the participants on Day 2 of the programme were where most change took place, particularly in communication and support for innovation. The research base used to develop the TCI was also used to inform the development of the programme (West & Markiewicz, 2004). The communication dimension of functioning revolves around sharing information, keeping in contact and interacting, and feeling understood and accepted. Support for innovation related to the development of new ideas and resources, allowing time and practical support, and being open and responsive to change. The clarity of objectives is founded upon how clear team members are about their objectives, how much they can actually be achieved, how worthwhile the team's objectives are to the wider organisation, and the extent to which team members are committed to those objectives. The fourth dimension, focus on quality or task focus, relates to the ability of the team to critically appraise their performance, and help each other to maximise their achievements.

It is notable that all these aspects were specifically explored within the programme (see Table 1) and participants were made aware of the comparative strengths and weaknesses of their team's performance on these dimensions by feeding back their scores on day two of the programme in comparison with CMHT norms.

That these improvements were not reflected in significant changes in staff morale and satisfaction is disappointing and may reflect changes in the team's context that were beyond the boundaries of the work undertaken within the programme (for example a facility not being opened on time or the lack of support from the programme from specific and influential team members). Our subsequent experience of running the programme has highlighted the importance of the preparatory stage where full sign up of the relevant stakeholders is achieved, particularly the immediate line managers of participants. It was this factor that led to the only programme, based within a prison, not reaching completion. When this issue was given more attention in another prison context the programme was completed successfully.

Perhaps the clearest message from the narrative provided by participants is the positive experience of action learning with others in a way that allows working across boundaries (e.g. statutory and third (voluntary and community) sector; inpatient and community). This is encouraging as it reflects the most novel aspect of this approach: working with participants across the local service system in a way that clarifies shared objectives and highlights the interdependency on others to achieve the outcomes sought.

As described earlier the ETL programme has already been widely applied to different care groups, and the principles applied to intervention with a stronger focus on senior management and work across organisations, such as the "Developing Effective Local Leadership for Social Inclusion" programme which was successfully piloted in three sites as part of the National Social Inclusion Programme (report available from first author).

Anecdotal feedback on the programme continues to be received with participants reporting that they were able to apply the skills learned in the programme in new settings and share them with colleagues. Since there seems to be interest in both applying the programme as a coherent whole and applying elements of it, the materials have now been made available via mindmaps through a the website for the national Learning for Improvement Network for Leadership and Teamwork Development (www.icn.csip.org.uk/leadership)

With the passing of central coordination of the programme through the Leadership Centre the programme has been widely adapted in application by the eight NIMHE/CSIP regional development centres. In some areas capacity building for facilitators has been done in partnership with local providers and their training and organisational development resources. This has allowed considerable throughput of participants and the fostering of mutual support for implementation. Others have used a train-the-trainers approach building a network of facilitators. While some have emerged as a strong resource that can be used in many contexts this approach has suffered from the challenge of maintaining contact with trainers whose roles continuously evolve and whose confidence rapidly wanes when they are not regularly involved in programme delivery. The hosting and local leadership of the programme therefore remain salient issues and 2007 saw the inception of the national Learning for Improvement Network for Leadership and Teamwork Development (see above) to consider such issues and the continued evaluation of the programme over the longer term. At time of writing, there is some organisational uncertainty concerning the host organisation for this resource. However, a social network for people interested in leadership and team development has been established at www.leadershipnet-icn.org.uk and the NHS Institute for Innovation and Improvement is developing a modular community team development programme as part of its "Productive" series (www.institute.nhs.uk) which should benefit from the experience described here, and that gleaned from a new large scale study of the "Effectiveness of Multi-Professional Team Working in Mental Health Care" lead by Aston Business School and funded under the National Institute for Health Research Service Development and Organisation funding stream (www.sdo.nihr.ac.uk)

Conclusion

Development and implementation of the ETL programme has highlighted the importance of clearly conceptualising teamworking issues based on sound research evidence, assessing the team's current performance, and then developing interventions and evaluating change specifically on those factors. Further attention is needed to embedding and sustaining change, for example by ensuring that there is strong senior sponsorship and support within the participating organisations, and building local capacity for ongoing development.

There is a need to develop capacity for delivering such whole systems interventions wherein thinking can be challenged, issues about authority and the exercise of power candidly explored, and where participants can continue to learn and adapt to ever-changing circumstances. The skills required of facilitators to achieve this are not inconsiderable and some infrastructure needs to be in place to ensure facilitators are adequately training, supported and developed.

Since the inception of the programme policy imperatives concerned with personalised care and wellbeing (HM Government et al, 2007; Department of Health, 2007), and mobilising the workforce to achieve it, (Department of Health, 2008) have further highlighted the importance of effective partnership working at local level. The challenge is now to continue to capture and disseminate the experience of effective local whole systems leadership and teamwork interventions in order to continue to develop this important form of whole systems development and make more widely available.

About the Author:

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Dr Carol Borrill, MSc. PhD. AFBPsS works in the NHS as Head of Organisational Psychology Division at Psychological Health Sheffield, and is involved in a wide range of practical organisational change, leadership and team development initiatives across different types of health care organisations. Her areas of particular expertise are team and leadership development, management of change and the development of interventions for reducing work and organisational sources of stress. Previously Carol worked as a researcher and senior lecturer at the universities of Sheffield, Aston and Nottingham where she conducted major research projects in the NHS, including investigating the causes of stress among staff working in the NHS, the effectiveness of multidisciplinary team working, the relationship between people management practices and hospital performance, and the implementation of employee involvement practices in the NHS. She has contributed to a range of 'Research into Practice' projects, funded by the Modernisation Agency, that ensured that the major findings from her health service research were disseminated and used within the service, and co-wrote the NIMHE 'Effective Teamwork and Leadership in Mental Health' development programme.

David A Shapiro, BA MSc PhD C Psychol FBPsS, led a team of research clinical psychologists at the MRC/ESRC Social and Applied Psychology Unit (SAPU) from 1977 to 1994. The team's research clinic developed and evaluated psychological interventions for depression and work stress. In collaboration with SAPU occupational psychologist colleagues, David also worked on organizational issues impacting upon mental health, well-being and effectiveness. Alongside establishing the Psychological Therapies Research Centre at the University of Leeds in 1995, he co-led major projects for England's National Health Service (NHS) on the mental health of the workforce and effective teamwork. He has also

worked within the NHS on psychological therapy service development, alongside consultancies for private and public sector organisations, including the NHS Leadership Centre. David has published some 150 peer-reviewed articles and edited two academic journals. He retired from psychology in 2006 and now pursues new interests in photography. His psychological work is documented at www.shapiro.co.uk.

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Table 4a: Within-team change on TCI dimensions

Team	Communication				Innovation				Objectives				Quality			
	M	SD	t	ES	M	SD	t	ES	M	SD	t	ES	M	SD	t	ES
1	0.93	0.85	3.65**	0.33	0.64	0.79	2.68*	0.75	0.21	0.5	1.48	0.56	0.62	1.15	1.86	0.26
2	0.13	0.59	0.68	0.45	0.13	0.42	0.94	0.44	0	0.59	1	0.29	-0.1	0.38	-0.76	1.59
3	-0.09	0.84	0.27	0.63	-0.31	0.6	1.38	0.84	-0.14	0.63	-0.61	0.18	-0.57	1.03	-1.47	0.47
4	0.09	0.54	0.4	0.15	-0.2	0.57	0.84	0.69	-0.14	0.4	-0.84	0.38	-0.1	0.38	-0.61	0.24
5	-0.27	0.57	1.57	0.52	-0.36	0.71	1.66	0.78	-0.36	0.56	-2.12	0.54	-0.08	0.57	-0.43	0.19
6	-0.13	0.5	0.46	0.62	-0.18	0.42	0.76	0.69	-0.39	0.05	-1.3	1.26	0.28	0.49	1	0.07
7	0.93	0.85	3.66**	-1.59	0.64	0.79	2.68*	-0.84	0.21	0.5	1.48	-0.58	0.62	1.15	1.86	-0.67
8	-0.58	0.54	1.86	0.77	-0.39	1.24	0.55	0.27	-0.48	1.1	-0.87	0.57	-0.79	1.05	-1.5	0.20
9	-0.56	0.71	2.50*	0.94	-0.57	0.87	2.07	0.82	-0.24	0.52	-1.43	0.50	-0.41	0.64	-2.03	0.72
10	-0.23	0.84	1.05	0.46	-0.33	0.86	1.5	0.62	-0.02	0.85	-0.07	0.36	-0.32	1.07	-1.17	0.37
11	-0.19	0.51	1.05	0.59	-0.31	0.4	2.18	0.80	-0.1	0.54	-0.54	0.32	-0.46	0.63	-2.07	0.76
12	0.01	0.51	0.04	0.02	-0.17	0.42	1.22	0.42	0.01	0.74	0.05	10.07	-0.1	0.59	-0.49	0.45
13	-0.17	0.66	0.59	0.54	-0.15	0.52	0.63	0.55	-0.11	0.39	-0.62	0.23	-0.4	0.57	-1.58	1.11
14	-0.43	0.66	2.34*	0.98	-0.5	0.53	3.38**	1.47	-0.13	0.66	-0.73	0.16	-0.35	0.63	-2.02	0.98

Table 4b: Within-team change on MBI dimensions

Team	Personal Accomplishment				Emotional Exhaustion				Depersonalisation			
	M	SD	T	ES	M	SD	T	ES	M	SD	t	ES
1	4.25	14.67	1	0.37	-2.33	7.67	-1.05	0.13	-1.08	4.34	-0.87	0.16
2	-1.5	5.15	-0.82	0.18	-3.78	8.39	-1.35	0.03	0.44	3.17	0.42	0.62
3	-2.43	9.09	-0.71	0.42	6.57	7.83	2.22	0.25	4.43	6.83	1.72	0.48
4	2.5	3.21	1.91	0.15	5.33	7.34	1.78	0.49	1	3.58	0.69	0.12
5	-0.55	5.26	-0.34	0.25	-0.27	3.07	-0.3	0.09	1.18	2.4	1.63	0.1
6	-1.33	5.51	-0.42	0.16	-2.33	2.31	-1.75	0.19	-0.33	6.11	-0.09	0.45
7	4.25	14.67	1	0.29	-2.33	7.67	-1.05	0.75	-1.08	4.34	-0.87	0.6
8	-8.67	10.26	-1.46	0.56	3	14.73	0.35	0.14	0.33	1.53	0.38	0.09
9	-2.33	3.2	-2.19	0.12	0.67	8.35	0.24	0.14	2.89	6.75	1.28	0.09
10	1.71	7.76	0.83	0.14	1.29	11.54	0.42	0.14	-1.57	5.5	-1.07	0.15
11	2.13	9.72	0.62	0.07	4.63	12.13	1.08	0.96	1.75	6.23	0.8	0.33
12	0.11	3.76	0.19	0.29	0.3	7.75	0.12	0.09	-6	3.75	-0.51	0.26
13	-0.6	2.7	-0.5	0.15	-1.8	5.72	-0.7	0.51	-0.6	2.51	-0.54	0.11
14	3.08	4.23	2.62*	0.38	2.08	8.58	0.87	0.22	3.15	3.65	3.12**	0.61

Table 4c: Within-team change on CMHTEQ dimensions

Team	External Requirements				Team Processes				Evidence and Feedback			
	M	SD	T	ES	M	SD	T	ES	M	SD	t	ES
1	0.54	1.32	1.43	0.09	0.68	1.45	1.63	0.35	-0.12	0.69	-0.57	0.21
2	-0.32	0.28	-3.46**	1.09	0	0.42	-0.01	0.57	-0.29	0.43	-2.04	0.99
3	-0.32	0.36	-2.34	0.68	-0.39	0.47	-2.19	0.4	-0.6	0.91	-1.75	0.56
4	-0.35	0.52	-1.64	0.58	-0.32	0.59	-1.34	0.58	-0.5	0.72	-1.69	0.68
5	-0.08	0.28	-0.99	0.05	-0.03	0.25	-0.37	0.07	-0.05	0.5	-0.36	0.11
6	-0.42	0.44	-1.64	0.53	-0.33	0.5	-1.15	0.52	-0.6	0.72	-1.44	0.82
7	0.54	1.32	1.43	-0.95	0.68	1.45	1.63	-1.01	0.58	1.5	1.28	-0.91
8	-0.14	0.58	-0.49	0.45	0.23	0.55	0.73	0.11	-0.07	0.57	-0.26	0.14
9	-0.31	0.35	-2.56*	0.67	-0.06	0.55	-0.3	0.52	-0.24	0.48	-1.54	0.38
10	-0.07	0.54	-0.49	0.41	-0.16	0.83	-0.75	0.57	-0.23	0.89	-0.96	0.39
11	-0.45	0.5	-2.51*	0.91	-0.3	0.7	-1.23	1.31	-0.2	0.89	-0.64	0.22
12	0.09	0.38	0.76	0.09	0.08	0.46	0.55	0.1	0.2	0.46	1.37	0
13	0.25	0.48	1.15	0.82	0.22	0.48	1	0.78	0.16	0.65	0.55	0.48
14	-0.04	0.34	-0.37	0.41	-0.23	0.42	-1.76	0.62	-0.12	0.54	-0.7	0.33