Understanding team effectiveness in healthcare: The case of high performance teams

ABSTRACT

The UK is experiencing a turbulent economic period and, as a result, all National Health Service (NHS) Trusts operate in a volatile, uncertain, complex, and ambiguous (VUCA) context. This context has had a significant impact on staff, patients, and other associated stakeholders. Teams play a key role within this healthcare environment. In 2012, 94% of NHS employees self-reported that they belonged to a team. High performing teams (HPTs) are acknowledged as outperforming their competition over an extended period of time, although the influential factors contributing to their success remain to be conclusively determined. Q methodology, involving five teams, face-to-face interviews and factor analysis of 44 emergent statements is employed in this study to explore the lived experience of HPTs within a NHS hospital trust. The findings reveal an initial high level framework of themes that are found to be significant in the modus operandi of HPTs. These include: supportive learning systems; shared community; courageous leadership; employment relationship synergy; courageous followership; and improving together. Conclusions draw together the primary attributes underpinning HPT success in a healthcare context. The limitations and transferability of these findings to other contexts provide opportunities for further research.

Keywords

High performance teams; healthcare management; learning; NHS; hospitals; Q methodology

INTRODUCTION

Global competition, harsh economic conditions, continuous innovation and new technological developments have marked the last decade within the UK as a period of *volatility* (Fairhurst and O'Connor, 2010). This volatility has prompted organisational restructuring,

downsizing and changes in the nature and structure of work. It has created *uncertainty*, with many organisations and individuals having to cope with higher demands and fewer resources than ever before (Ronald, 2015). The *complex* new challenges emerging, with no obvious precedents and no clear solutions to move people, departments and organisations forward has led to *ambiguity*. Ambiguity comes in many forms; the boundaries between work and non-work life are increasingly blurred, with internet and mobile technologies both enabling employees to work extended hours from any location, and overloading them in the process (CIPD, 2012). As a result of this dynamic, yet turbulent VUCA (volatility, uncertainty, complexity, ambiguity) environment, organisations are considering their sustainability and viability, seeking effective, efficient and innovative solutions to emergent problems.

In order to address these challenges leaders continue to look to their people for the answers with some noticeable patterns emerging. Business results are becoming even more dependent on teams performing at exceptional levels (Drucker, 2013). Better, more efficient solutions, delivered in record time, are requiring greater breadth of thinking by fully engaged employees (Johansen, 2007). Diversity of thinking has become a prerequisite to success in a landscape of working across boundaries and borders (Wolf, 2007). Such is not without consequences however, as workforces studies (Fairhurst and O'Connor, 2010) suggest that VUCA is impacting upon employee effectiveness manifested by: a growing anxiety over the future; employees working longer hours, taking less time off and reporting higher stress levels; increased levels of sickness absence; and increased intentions to leave an organisation. Wolf's (2007) assertion that the VUCA environment can be managed and potentially used to the advantage of the organisation suggests a need to establish which employment models are most effective in this environment. Healthcare provides the context for this investigation.

Organisations operating within the healthcare landscape are experiencing their own VUCA environment. The increasing prevalence of complex, chronic illnesses and diseases and disabilities linked to demographic and epidemiological transitions i.e. increasing life expectancy, an ageing population and a low premature mortality respectively (Yukl, 2012; WHO, 2010) are placing an additional burden upon existing services. The impact of the austerity measures introduced by the government on the NHS persist leading to ambiguity and uncertainty in the workplace and working conditions. Staff turnover and personnel shortage continue to dominate recruitment and retention strategies (Sloane *et al*., 2005; WHO, 2010). This in turn has the capacity to demotivate and disengage employees in the near-term impacting upon both employee wellbeing and, consequentially, patient-centred care. It is now widely recognised that there is a need for fundamental change in thinking, practice and delivery of UK healthcare over the next decade (see for instance NHS, 2014). Effective inter- and intra-teamworking and collaboration has become increasingly prioritised in healthcare policy both nationally, and internationally (Darzi, 2008), in-line with management strategies elsewhere too.

Katzenbach and Smith (1993 p. 45) describe a team as "a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable". According to Schipper et al (2008, p. 1594), "teams have become the basic organizing structure for accomplishing work in many firms, especially for the increasing numbers of organizations operating in dynamic and complex environments". For the individual employer and employee, effective teamwork is acknowledged as assisting in lowering absenteeism, staff turnover and levels of stress (West et al. 2011), improving job satisfaction (Buttigieg et al. 2011) and improving psychological engagement (Abualrub et al. 2012). Yet what underpins effectiveness varies in research. Proposing a 'shared mental model' Kang et al (2006) demonstrates that effectiveness is a by-

product of cognitive rather than demographic similarities. For Schippers *et al.,* (2015), team reflexivity, facilitated through transformational leadership, lies at the heart of effectiveness.

Teams are constituted in multiple ways. There is a growing evidence base (Grint, 2013; West, 2014) that high performance teams (HPTs) in particular consistently outperform competition over an extended period of time and outperform the expectations of their key stakeholders. Katzenbach and Smith (1993) argue that what sets HPTs apart from teams more generally, is the level of commitment they exhibit. Indeed, Plamping *et al.,* (2009) and Grint (2011) go as far as to suggest that the future of the services delivered by the NHS would be bleak if it were not for the commitment of HPTs to delivering innovative services to patients. But the particular characteristics of, the why and how HPTs improve practice, and the factors which influence their success remain to be conclusively determined. The primary aim of this paper is to explore this within the UK National Health Service (NHS) context. The paper will examine the literature on HPTs, and seek to better understand the perceptions of HPT members and other stakeholders as to their success. Through an application of Q methodology, explanations for their success will be extrapolated and conclusions reached helping us to understand more fully the role they play within a VUCA environment. The operational framework emergent within the findings presents opportunities for future research.

Literature review

Understanding teams

The general premise that teamwork will generate outcomes superior to individual work renders the label 'team' appealing. It is consequently assigned to all sorts of groups (Allen and Hecht, 2004; Nurmi, 1996). However, in practice, teams vary dramatically, both in structure and impact. Not all organisations are suited for team-based work, not all groups are 'teams'

and not all teams are effective (West and Lyubovnikova, 2013). In the healthcare sector if placed on an effectiveness continuum, teams would vary from 'exceeding expectations of effectiveness' to 'not meeting expectations and ineffective' or 'superior patient outcomes' to 'damaging patient outcomes' (Care Quality Commission (CQC), 2010). Ineffective health care teams (poorly communicating and poorly collaborating) have been found to account for 70% of medical errors (Studdert *et al*., 2002). Effective teamwork is associated with improved mortality hospital rates (West *et al*., 2011), greater patient satisfaction (West *et al*., 2011), increased patient safety (Firth-Cozens, 2001), reduced medical errors (Manser, 2009), more effective use of resources (West *et al*., 2011), reduced physician visits and hospitalisation rates (Sommers *et al*., 2000) and more streamlined and cost-effective patient care (Ross and Furne, 2000).

Many theorists have attempted to dispel the notion that teams are static and linear (Kozlowski and Bell, 2003; Kolowski and Ilgen, 2006) and tackled what characterises a 'good' team. Hollenbeck *et al.* (2012) describe a team as having three underlying dimensions: skill differentiation, authority differentiation and temporal stability, with effective teams demonstrating a high and appropriate skill set, recognised authority and stability. WHO (2010) asserts that a good healthcare team is small in size (optimal size being six to eight), has clearly defined goals, well-balanced skills, a common approach, as well as mutual accountability. Scholtes *et al.,* (2003) position effectiveness around: team leaders, team members acknowledging the leader and demonstrating follower membership, and for the team structure to have a power dimension. Katzenbach and Smith (1993) developed a team performance categorisation curve based on anecdotal experience (albeit broad and expert). More recent studies (West and Lyubovnikova, 2012; West *et al.,* 2012; Cohen and Bailey, 1997) have since validated the categorisation, although their methods did not involve measurement of outcomes.

Teams are the most prevalent structures within healthcare organisations working often in very challenging, difficult and complex environmental situations (West *et al.,* 2012). The NHS is reputed to be the fifth largest employer in the world, with a workforce of 1,700,000 people, 90% of the staff questioned in a CQC study (2010) reported that they worked in a team, a number growing year-on-year, although only 40% of staff went on to report that their team had clear shared objectives, worked closely and interdependently and reviewed its effectiveness on a regular basis.

Successful outcomes in healthcare are inextricably linked to team success (West *et al.,* 2012) and therefore each healthcare organisational decision made directly impacts on teams. However, the sheer presence of a team structure does not automatically generate successful outcomes. Whilst Salas *et al. (*2009) found that effective teams provide diversity in knowledge, attitudes, skills and experience, Sims *et al*., (2005) note, healthcare teams do not always achieve the performance expected of them. Hollenbeck et al. (2012) links this in part to the changing patterns of skill differentiation found in them, uni-versus multi-skilled teams. The CIPD (2010) questions the implications of low levels of employee engagement, highlighted in particular by the Francis Report (2013) which examines the failure of a NHS Foundation Trust Hospital. Both Bevan et al. (2005) and Schippers *et al.,* (2015) demonstrate that successful team operations, high performers, are linked to the leadership component of the team function.

High performance working and high performance teams

Multiple studies have attempted to understand what constitutes high performance working (HPW). For instance, Glover and Butler (2012) describe HPW as a set of conceptual approaches, which stem from strands of post-Fordist practices. Wood and De Menezes, (1998)

have traced the debate from the use of the term 'high commitment management' by Walton in 1985 through 'high involvement management' in 1986, into debates linked to 'high performance management', or 'high performance organisations'. Gordon (2000) asserts that three elements encompass essential traits of a high performance workplace: technology (machinery, software); process (systems, structures) and people (knowledge workers). For Godard (2004) HPW are conceptualised as comprising three basic components: an opportunity for substantive participation in decisions; training and selection policies to guarantee an appropriately skilled workforce; and appropriate incentives (including extrinsic and intrinsic incentives).

Whilst no one definitive appreciation of HPW currently exists (Glover and Butler, 2012), the high performance paradigm has come to be promoted as 'best practice' for employers and organisations on the grounds that the practices associated with it yield performance levels above those associated with more traditional workplace and employment relations' practices (CIPD, 2012). People can be viewed as a potential source of sustainable competitive advantage and are sometimes referred to as 'human assets' or capital (Becker and Huselid, 1998). Macky and Boxall (2007) use terms such as high performance work systems (HPWS), intellectual capital, intellectual and social asset and knowledge management, inferring that people are viewed as an investment or considered an asset to be valued, rather than a cost to be minimised.

Bevan *et al.* (2005) argue that cultural norms, leadership and high performance are inextricably intertwined in HPW. These cultural norms include, a distrust of the status quo, valuing quality over quantity, external and internal focus and a sense of pride. Bevan *et al.,* (2005) argue that organisations which aspire to high performance need to be led by many

people, in many positions. The shift in focus is to leadership as a mediator. Leadership is no longer the domain of the CEO or the top level executive team, but all employees (Kotter, 2011). Thus the HPT leadership can emerge from any level in the structure. The need for leadership devolvement, to allow workers as much control as possible over when, where, and how the job is done, is seen to be critically important. Such an approach moves from task focused control and command to a balanced focus on people being autonomous and responsible (Bevan *et al.,* 2005). HPW leadership practices are thus underpinned by reciprocity in the employment relationship, enabling empowerment, trust and support throughout all structures (Moss Kanter, 2011). Through this, individuals are encouraged to be courageous and wise, whilst engaging in meaningful work, focused on the shared objectives. Such generates an output of HPW culture, rather than HPW intricacies and complexities being inputs.

High performance teams (HPTs) have emerged as a major source of competitive advantage within the NHS, linked to tacit knowledge and practices, exceptionality and evolution (Keroack *et al.*, 2007). Collins (2001) suggests that HPTs that are disciplined and hard-working are essential in order to move organisations from good to great. Erhardt et al., (2011) asserts that when there is high performance teamwork, the outputs are outstanding, and this high performance mostly correlates with engaged employees. Keroack *et al.* (2007) concluded that successful teams were passionate about improving quality, safety and service, and had a hands-on style, leveraging a competitive advantage to improve consumer experience. Whilst no one definitive explanation of HPTs exists, what is acknowledged is that high levels of effective teamworking and employee engagement are more productive, innovative, efficient, customer-focused, safer, and more likely to withstand temptations to leave the organisation than teams with only transactionally engaged members (Bevan and Hood, 2006; Keroack *at*

al., 2007; Grint, 2010; Grint, 2011). The reciprocal employment relationship at a team level and organisational level has been found to promote wellbeing and act as a mediator for success.

Despite the plausibility of these arguments, relatively few studies have provided empirical insights into how the HPTs develop and manage the 'know how' (tacit) and 'how do they' (explicit) knowledge and practices of their teams. Kotter (2011) argues that employees believe that high performance environments nurture meaningful work, a sense of belonging and identity, the attainment of goals, autonomy and responsibility and want to be reflexive and adaptive. But the particular characteristics of, the why and how HPTs improve practice, and the factors which influence their success remain to be conclusively determined. This paper will now examine these questions through an empirical study of the UK National Health Service (NHS).

METHODOLOGY

Research Design

Q methodology (Q) is a triangulated qualitative and quantitative research design which seeks explanation and explores subjectivity. Whilst gaining in popularity (see for instance Bryant *et al.,* 2006; Baker, 2006; Van Exel *et al.,* 2005; Tielen *et al.,* 2008; Kreuger *et al.,* 2008; Boot *et al.,* 2009; Cramm *et al.,* 2010; Jedeloo *et al.,* 2010; Wallenburg *et al.,* 2010) it is still relatively novel in some social science disciplines and rare in team-based research. It uses narrative data to capture the broad range of representations in relation to a specific area of inquiry (Brown, 1980). In Q, the participant's subjective viewpoint is known as his or her self-reference on a topic. A key aim is to ensure that this self-reference is preserved rather than compromised by the researcher (McKeown and Thomas, 1988). It seeks understanding of the

lived experience so engages the attention of the researcher interested in more than just measurement (Watts and Stenner, 2012).

Q methodology is predicated upon five stages: *Concourse* - develop the whole representation of the topic; *P-Set* - identify the participants' viewpoints; *Q-Set* - undertake synthesis of the concourse into a set of representative statements; *Q-Sort* - carry out individuals' representations of the topic; and *Factor Analysis* - conclude with analysis to identify families' of similarities.

Concourse: Brown (1993, p. 94) suggests a concourse should incorporate 'virtually all manifestations of human life, as expressed in the lingua franca of shared culture'. It can be informed by many things including the research participants, published literature and any other source of knowledge or other stimuli, for example, pictures, music or video clips. Figure 1 assembles the literature components contributing to the concourse in this study. Semi-structured interview data provided the further concourse component.

[Insert Figure 1 about here]

P-Set: The P-Set represents the participants involved in a study. A multi-ward winning NHS Trust, credited as one of the top NHS organisations in the UK for their high performance in patient care was chosen to be the case study. Five teams representing community based teams, theatre operational teams, hygiene services and multidisciplinary governance support teams were invited to take part in the study. To be included, teams had to be award winning at a local, regional and national level within the last five years and to have been nominated by their peers, colleagues and patients for their contribution to patient care and experience.

Diversity in the range of teams was introduced to ensure that the research participants were representative of HPTs operating within this organisational context. All teams had an appointed team leader. A total of forty team members were purposively selected to represent different levels and roles within the team. All were united in having a personal investment in HPTs.

Q-Set: The Q-Set (known as a Q sample) is developed through theming, filtering and sampling of the concourse. It comprises qualitative data. The goal of the Q-Set is to provide a condensed version of the concourse (between 40 and 80 statements is usual) without losing any of the comprehension in terms of content and representativeness (Van Excel and de Graaf, 2005). The Q-Set statements are not considered to be absolute 'facts' and, prior to the sorting process, are deemed to be equal in value. They are ascribed meaning by the participants and given value and significance, depending upon their subjective experience, understanding and interpretation of the statements (Watts and Stenner, 2005). The Q-Set was developed through the series of one hour semi-structured interviews (n=40) (see Table 1). Instructions for completing the card sort activity were provided. The Q-set is a practice representation of the HPT modus operandi. Participant demographic data was also collected (see Table 2). Theoretical components (see Figure 1) were used to bring structure to these interviews. All interviews were recorded and transcribed verbatim.

[Insert Tables 1 and 2 about here]

Q-Sort: The Q-Set sort procedure provides quantitative data. It is described as 'the technical means whereby data are obtained for factoring' (Brown, 1980, p. 17). It involves individual participants ranking their statements (subjective viewpoints) on a grid. The grid design usually reflects a quasi-normal distribution, but not exclusively so (Brown, 1993). The

design of the grid is specific to each project. The same statement can represent different meanings (or constructions) for different participants. Each study participant was provided with a set of instructions and invited to sort the Q-Set statements in order of importance (Q-Sort). Following the relative ranking of each statement participants were interviewed to share their opinions of both the process and their lived experience of working in HPTs. Questions asked included: how did you decide on the most and least important statements? How did you find the sort process? And was anything missing or would you add anything? Again all interviews were recorded and transcribed verbatim. All visual materials presented (Q-sorts) were photographed with consent.

Factor Analysis: By-person factor analysis is used on completed Q-Sort to determine the extent to which individual Q-Sorts correlate highly with one another and therefore can be considered to have a 'family resemblance' (Brown, 1993), known as a 'factor'. The number of factors extracted from the data, and the way in which these are interpreted and described, are a matter of judgement and dependent upon the individual researcher. This interpretation will be influenced by the researcher's philosophical leaning (Stainton Rogers, 1995, p. 191) as well as statistical and theoretical processes.

Data analysis

Watts and Stenner (2012) assert that a Q-study involves three methodological transitions: transition one: from Q-Sorts to by-person factors; transition two: from factor to factor arrays; transition three: from factor arrays to factor interpretation. The dedicated software package PQMethod 2.11, as suggested by Schmolck and Atkinson (2002), was utilised to analyse the data (transitions one and two). However, as Brown (1991, p. 13) reminds us "the statistical and mathematical aspects of Q serve primarily to prepare the data to reveal

their structure in readiness for qualitative factor interpretation" (transition three). Q utilises both quantitative and qualitative methods to analyse and interpret phenomenon.

FINDINGS

In transition one a total of 15 factors were retained that had an eigenvalue of one or more. These 15 factors accounted for 85% of the total cumulative variability. It is usual to keep factors that are representative of approximately 70% of the study (Watts and Stenner, 2012). Transition two involved the production of a factor array which exemplifies, as a best fit, the position of the statements within that factor. From the original 15, eight factors were identified as significant and are interpreted in this study (see Table 3). Factor one accounted for 10.5% of the variance, whilst the remainder hold a similar weight (between 2.7 and 2.3) and account for 43% of the variance. It is usual to interpret 40% of the variance (Watts and Stenner, 2012) so all are included in the following review.

[Insert Table 3 about here]

Factor One: Supportive Learning Team

This factor is a culmination of the HPT commitment to learning and development that is sustainable. Eight statements (see Table 3) underpin this factor, represented through the sub-themes: the learning team; the expert team; and the emotionally intelligent team. Continuous improvement alongside the ability of individual's to negotiate and manage team dynamics whilst maintaining authenticity of the individual and the cohesion of the team are embedded in this factor.

The Learning Team: There are a grouping of statements which infer that HPT members are capable of working in a fast-paced environment and contribute in full. They are supported and nurtured to adapt and change in a team context that lends itself to autonomy, curiosity and innovation (Gordon, 2000, p. 18). Team autonomy and individual autonomy contribute to team learning and so to team wisdom. Reflexivity in HPTs by team members is the norm. They regularly and systematically reflect on their performance, learn and adapt to improve future practice and process (WHO, 2010; Hollenbeck *et al.,* 2012). Team composition counts, and the reflective sharing of knowledge and experience underpins wisdom, which in turn brings about innovation. The opportunity for leader/follower development is pivotal to maximise an individual's learning and contribution in a HPT.

The Expert Team: There are a grouping of statements in this factor that indicate a correlation between continuous learning, peer-to-peer support, development, an expertise ethos and consistent high levels of performance. Social cohesion is regarded as an asset, and along with the HPT's knowledge and learning (intellectual asset), the team develops expertise. An effective team's integration makes it possible to offer rapid, flexible and innovative responses to problems and challenges (Salas *et al.,* 2009); therefore, social cohesion contributes to learning and expertise. Sustaining continuous and consistently high levels of performance arguably delivers competitive advantage and a high value work proposition. To further this argument, Moss Kanter (2011) argued for decentralisation of power; enabling good, well-functioning teams to create something greater than the sum of the individual contributions (Andreatta, 2010; Nurmi, 1996). Empowerment, autonomy and localised decision-making, as well as knowledge management and team learning, have all been argued to be HPW mediators.

The Emotionally Intelligent Team: An array of statements infer that emotional intelligence is part of the unsaid modus operandi of HPT members. Emotional intelligence is associated with an awareness of the interpersonal dynamics occurring, at any given moment, between and among the individuals within a contextual relationship (Goleman et al. 2003). The ability to sense, translate and communicate these nuances and dynamics is critical for the reduction and/or elimination of hidden agendas, underlying biases and unspoken prejudices. In this sense, the HPT member's relationship management skills become paramount (Conole, 2002). The use of emotional intelligence permits a timely and authentic discussion of 'what is not being said but is being experienced'. The question, often asked after the fact, 'Why didn't I say something right then instead of stewing about it and letting it fester?' epitomises the inefficiency resulting from a lack of emotional intelligence. As with confrontation, the use of immediacy challenges the individual's ability to use sensitivity, self-awareness and self-management as 'tools of action'.

Factor Two: Shared Community

Six statements (see Table 3) representing four sub-themes are linked to this factor: organisational citizenship behaviour; discretionary behaviour; patient wellbeing results from employee wellbeing; and improvement and innovation through risk and strategic governance.

Organisational citizenship behaviour (OCB): There are a grouping of statements that are associated with belonging, community, positive engagement and discretionary effort. This is supportive of the concept of organisational citizenship behaviour (OCB) which suggests that HTPs voluntary commitment is above and beyond that which is their contractual task. HPT members who display OCB are more disposed to experience stronger attachment to their role, have less time off work, have reduced turnover intentions and have positive mental well-being,

better work-life balance and reduced stress levels. Rich *et al.* (2010) argue that OCB is an outcome of positive engagement which is good for everyone: the employee, the employer and the patient. Through positive engagement the quality and quantity of care is substantially improved, the organisation is more stable, sustainable, effective, and likely to innovate whilst improve efficiency and quality.

Discretionary behaviour: Positive discretionary behaviours arising from OCB (Rich *et al.* 2010) are those that go beyond the formal job description requirements, and are performed by the employee as a result of personal choice. Thus HPT discretionary behaviours positively contribute to the overall organisational effectiveness and organisational functioning (Organ, 1988). Kahn (1992) asserts that engaged employees are likely to be more willing to initiate positive discretionary behaviours because of their involvement in a positive cycle of input and rewarding outcomes.

Patient wellbeing results from employee wellbeing: The focus of a collection of the statements is the balance between positive patient well-being and positive employee well-being and engagement. In order for successful, high quality care to be delivered to service users, teamworking must be attractive to compassionate and dedicated people. Compassion and dedication should be recognised and rewarded as a valued personal trait (West *et al.,* 2012). Effective teamworking and employee engagement are more productive, innovative, efficient, customer-focused and safer. Good patient-centred care, patient safety culture and the quality of care are a result of good employment engagement (Lowe, 2012). Grint (2010) found that the world's top-performing health organisations understand that teams are a force that drives improved health outcomes and the reciprocal employment relationship within the organisation is pivotal.

Innovation using strategic governance: A particularly interesting finding is linked to an array of emergent statements that can be interpreted as creating positive attitude towards risk management and the strategic use of governance. This area of knowledge is largely absent within existing HPT literature, yet was represented through statements including: "we confidently use the governance arrangements to engage in continuous improvements" and "we actively innovate and are confident in managing the associated risk to improve our service".

Factor Three: Supportive Learning System through Leadership

Here supportive leadership is positioned as encouraging team learning and knowledge exchange to evolve and flourish. Five statements are associated with this factor (see Table 3).

Team learning: As the literature indicates, team-based social cohesion develops trust and nurtures learning, and learning reveals itself in many guises. All members of the team are involved in learning and development, and all members are supported in many different ways. Within this developmental learning space, managers are seen as equal partners of the learning community. Findings identified a very broad array of learning opportunities open to HPT members. These include informal approaches, such as, peer-to-peer reflexive practice, shadowing, coaching and mentoring and semi-formal opportunities including team incident reviews, team briefings and learning circles, regular team meetings set aside dedicated time to shared learning and team development. The more formal learning opportunities include expert networks, regional and national conferences and external learning programmes. All of these learning opportunities result in a cascade learning and development effect across the HPT. With this supportive learning environment progressive leadership practice and positive engagement

are vital. Continuous improvement and innovation blossoms as HPT members as learners are constantly revitalised and re-energised through these informal and formal learning processes.

Knowledge management (innovation through divergence): HPT learning brings about knowledge management to maximise an organisations' ability to solve problems. Other qualities that are critical to successful innovation are courage, curiosity, integrity, empathy, and drive (Johansen, 2007). Successful innovation relies on people, and people have different cognitive approaches for assimilating data and solving problems, known as cognitive difference (Garvin and Roberto, 2001). Indeed it is cognitive factors which have been previously found to influence team effectiveness (Kang et al 2006). Innovation takes place when different ideas, perceptions and ways of processing and judging information collide.

Cognitive difference needs a mechanism to pool divergent thinking. This pooling or emergence of divergent thought is part of the HPT modus operandi, and often takes place in facilitated environments such as team meetings. Successful growth of ideas, in turn, often requires collaboration among various team members who see the world in inherently different ways. Ashton and Sung (2002) assert that a supportive team environment uses their collaborative approach to support creative problem solving leading to innovation. As a result, in HPTs, conflict is a constructive and productive process among people who innately understand one another; as a result disputes do not become personal and the creative process is enhanced. Innovation is accomplished because the whole team, irrespective of roles and responsibilities, work synergistically to transform their teams' service (Janis, 1982).

Factor Four: Getting Better Together

Six statements (see Table 3) can be themed around getting better together. The two dominant sub-themes emerging are: HPT synergy and team congruence.

HPT synergy: HPTs are recognised as producing effective outcomes, generating a productive work environment and creating synergy (Salas *et al.,* 2000; Zwarenstein and Reeves, 2000; Lawford, 2003; Saunders *et al*, 2009). Synergy is the creation of a whole that is greater than the simple sum of its parts. Aubrey (2005) and Salas *et al.* (2000), assert that effective team performance or synergy among a group is by nature elusive and dynamic, fleeting and possibly even mystical as it lacks a prescriptive process that suggests that synergy cannot be manufactured. Statements such as "the team is much bigger than the individuals within it" reaffirms the centrality of synergy within this study.

Team congruence: The world's top-performing companies place their focus and philosophy on engaging their workforces through their team structures (Grint, 2010). The team structure and composition is therefore of paramount importance as is the relational environment in which the team operates (Grint, 2010; Keroack *et al.,* 2007). Statements generated positioned participants as recognising that the organisational leadership and team brings about employee cognitive congruence: "credibility of our team's service comes from us maintaining high levels of expertise". Such are recognised as critical elements in HPTs with the symbiotic relationship generated, a mediator to positive patient outcomes (Grint, 2013).

Factor Five: Employment Relationship Synergy

The five statements (see Table 3) contributing to this factor can be separated into two sub-themes: positive practices; and positive engagement.

Positive practices: this subtheme includes teams recognised as caring, compassionate and supportive who demonstrate forgiveness, respect, and integrity as well as gratitude and inspiration (Cameron *et al,* 2004). Empirical data collected consistently found that members of HPTs care for, are interested in, and maintain responsibility for one another as friends. Team members provide mutual support, demonstrating kindness and compassion when others are struggling. Team members avoid blame and forgive mistakes. Members treat one another with respect and express appreciation for each another. They trust one another and maintain integrity. The meaningfulness of the team's responsibilities is emphasised, and people are elevated and renewed by their work. All of these practices converge around three notions of positive practice, which are positive deviant performance, affirmation bias and virtuousness (Cameron *et al,* 2004). Positive deviance, extends beyond achieving effectiveness or ordinary success in that it represents 'intentional behaviours that depart from the norm of a reference group in honourable ways' (Spreitzer and Sonenshein, 2003, p. 209). Affirmative bias focuses on strengths, capabilities and possibilities rather than on problems, threats, and weakness (Baker, 2000; Cameron, 2008). Virtuousness in positive practice, is based on a eudemonic assumption that an inclination exists in all human systems towards goodness for its intrinsic value (Cameron *et al*., 2004, Peterson and Seligman, 2004).

Positive engagement: In this statement array, positive engagement was prominent. HPT members appear motivated, engaged and focused on opportunities that positively contribute to and improve their groups' situation, which ultimately supports the notion of positive engagement (Harter, *et al*., 2002). When positively engaged, the HPT members are connected at a rational, emotional and motivational level (Adyasha, 2013). Personal fulfilment is attained from physical, cognitive and emotional energy alignment which reinforces the teams' positive practices. The individual is more disposed to experience stronger attachment to their role, have

less time off work, reduce turnover intentions and have positive mental well-being, better work-life balance and reduced stress levels.

Factor Six: Courageous Followership

Three statements (see Table 3) are themed around courageous followership. They refer to HPT members making changes, being confident to challenge and having the courage to innovate. Whilst each individual continually strives for improvement, these cited examples are all recognised practices of courageous followership, described by Yukl (2012) as followers who do not wait for permission and, if needed, will openly ask for forgiveness after their courageous event. The HPT member is well placed to develop their own capability and capacity, as devolved management supports autonomy and localised decision-making in a HPW context. The courageous followers within HPTs move away from the Fordism principle of deskilling and micro management, towards upskilling and independent autonomy, learning through reflection and becoming wise decision-makers as inferred by factor one, ultimately resulting in their learning leading to expertise. A courageous follower is more than just a responder to the leader; they can be recognised as a leader in different places in the organisational dyad, and one who Storey *et al*., (2010) assert may be the defining factor between mediocre and successful HPTs.

Factor Seven: Getting Better Together – Identity

The four statements associated with this factor (see Table 3) are themed around getting better together. This is aligned to factor four, in this instance including the sub-themes of identity and the HPTs evolving identity into becoming an expert.

Identity: Within this factor, there is a strong emphasis on the identity of the team as well as the identity of the team members. The team and its members are equally striving to become experts, so the inference is that identity, as a construct within HPTs, is moving over time from good to great and that the HPT identity shift has a value associated with it, as does the individual identity as a member of the team. Debates continue as to whether identities are stable, fixed and secure, or evolutionally adaptive, malleable or even perpetually fluid and shifting. Social psychologists suggest that people in organisations require 'a relatively secure and stable' understanding of their selves in order to function effectively (Ashforth and Kreiner, 1999, p. 417). Yet there is increasing recognition that, while self-concepts may exhibit continuity, there is also scope for flexibility provided by a suppler 'working self-concept', which permits dynamic responses to changeable situations (Markus and Wurf 1987).

Expert identity: HPT members aspire to expertise, the team's identity is then associated with expertise, which further develops the HPTs social and intellectual capital. Much of this is the result of what has been called the wisdom of crowds: increased capacity for achieving various types of performance made possible by the interaction of team members and continuous learning (Salas *et al.,* 2009). Statements such as "my team identity is a source of great pride" and "positive recognition is common in our team" shifts the identity of HPTs beyond meaningful to one in which expertise and excellence is an intrinsic element of social kudos or capital.

Factor Eight: Courageous Leadership

This factor comprises of four statements (see Table 3) and two emergent sub-themes: wisdom of the crowd (team learning); and courageous leaders and shapers.

Wisdom of the crowd - team learning: Hollenbeck *et al.* (2012) assert that the learning team has a positive impact on both the individual and the team through its capacity to engender a collegiate community of practitioners. As behaviours mature over time, along with reflexive practice, the ability to fully contribute improves for both the individual and the team. The positive impact of reflexivity, personal growth and learning that happens over time were pivotal to responses provided in this study. All participants made reference to open access learning opportunities with some learning opportunities very creatively generated. To exemplify, one participant approached several providers of dressing cover supplies and requested a half day training session so that the participant could obtain sufficient insight into the subject of dressings in order to become an expert. This expertise subsequently underpinned one of this particular team's awards.

Continuous, embedded reflexive practise brings about diversity in knowledge, attitudes, skills and experience. Team members interact among themselves and with other colleagues and these interactions change the teams, the team members, and the environments in which they operate in in ways which are more complex than is captured by simple cause and effect modelling. HPTs differentiate themselves from other teams by offering rapid, flexible and innovative responses to problems and challenges. The capacity of the team to change form and function, in order to reflect the team's shared objectives is peculiar to HPTs and is known as organic metamorphosis.

Courageous leaders and shapers: Supportive enabling leadership is regarded highly within the HPTs, and has been a sub-theme in many of the factors discussed. Good leadership within HPTs is associated with clarity in communication of aims and objectives; a positive working environment that values trust, autonomy, localised decision-making; and

independence, that facilitates learning and growing together. The emphasis within the focus of the statement is on the reciprocity of a leadership and a followership relationship. The thread that connects leaders to people and people to purpose epitomises HPT leaders; thus inferring that team synergy is the norm within the HPW, and that the leadership focus is one of mutuality, autonomy and respect (Yukl, 2012). The teams' cohesion engenders sustainable emotional engagement that develops emotional resilience within the individuals and the team (Mathieu *et al*., 2008).

Cohen and Bailey (1997) assert that a leader should be focused primarily on the team's internal processes that occur within the team boundary. Faraj and Yan (2009) state that the team leadership function should have a balanced perspective and emphasise an external perspective. The distinct roles and boundary activities that team leaders initiate and perform in order to promote team effectiveness are coming under deeper scrutiny. Druskat and Wheeler (2004), along with Mathieu *et al*., (2008), suggest that good leaders enable good followers and that they should share their role and responsibilities, as well as their decision-making and autonomy throughout their teams.

It is argued that leadership in HPTs enables good followership, and striving further to enable courageous followership. Using the participant responses from this research, the leaders of the HPTs could be recognised as being transformational leaders. This assertion is based on the seminal work of Goleman (1995) whose transformational leadership framework is underpinned by an enhanced level of self-awareness and emotional intelligence. HPT leaders do not seek the limelight for themselves but challenge, stretch and champion others, giving HPT members the space and support to excel (Luth and May, 2012). This supportive, courageous leadership approach, evidenced within all of the HPTs contributing to the study,

enables and encourages others to become the best team contributor that they can be which, in turn, motivates fellow HPT members in their own performance.

CONCLUSIONS

This paper set out to better understand the factors which enable HPTs to outperform their competition over an extended period of time. The UK National Health Service (NHS) provided the context for the work and Q methodology the means of data collection.

Understanding what equips a HPT to improve practice can be determined by analysing the multiple attributes which characterise their operation. In this study these attributes include: that they are complex, adaptive, dynamic, people-centric, learning systems embracing ambiguity, diversity and welcoming change. The prize their essence, identity and boundaries. They perform at levels of excellence and innovation beyond those of comparable systems. These attributes suggest a HPT operational framework which is characterised by: a clear, well-understood common and individual purpose; meaningful roles and clear team and individual identity and agency; integrated, supportive teamwork and team learning to achieve tasks; courageous, wise leadership that promotes trust, support, curiosity, and encourages devolved autonomy, learning and decision-making; judicious followership that is adaptable; cyclical, shared reflexivity, which builds competence, confidence and esteem, and commits to wise continual improvement; highly engaged individuals, interacting with each other and the organisation, which results in high levels of energy, motivation and commitment; and populated by members who are ambassadors and develop intra- and inter-team learning, knowledge sharing and relationships.

To meet the increasing demand on patient centred care and services and the increasing complexity of patient conditions, teams have, and will continue to play a pivotal role in the healthcare environment. Good, well-functioning teams create something greater than the sum of the individual contributions. Complexities within the working environment are putting more stresses and pressure on teams to maintain a continuous and consistently high level of performance. Adopting and adapting an operational framework such as that epitomising HPTs offers opportunities for organisations to maximise and achieve success in their working practices.

Future Research: This study collected data from multiple teams located within one healthcare setting. Whilst there is no reason to believe such is an atypical setting, the opportunity to repeat this work both within, and outside healthcare is considerable. Any replication or extension of the work might usefully include the consequential impacts of HPW too. Questions to explore include: what is the impact of maternity leave or a leave of absence upon HPW for instance? Does this style of working generate unsaid pressures and enhanced expectations? Does HPW reduce the capacity of team members to move around an organisation and benefit from knowledge exchange ordinarily present in such moves? The knowledge generation and sharing that occurs within the high performance system represents an intellectual and social asset that needs to be fostered. However, to-date, the majority of empirical work in this area has focused at an organisation level and not a team level. Given HPW extends to individuals and teams, not just organisations, there is a need to explore the team level further and in different contexts. This, in turn, will add to the body of evidence sought in determining whether such can be usefully promoted as a strategic competitive advantage and asset by future governments (DTI, 2003) and organisations more generally.

Identity emerged as a subtheme within this study. Identity evolved from HPT practice, producing social capital. However, although identity work has a temporal dimension (Yukl, 2012), explicit 'theorising about time in identity research is relatively rare' (Pratt, 2012, p. 28) and so is theorising the identity of HPTs and their impact. The notion that identities provide people with a sense of temporal coherence has received limited scholarly attention (Alvesson, 2010). Whether HPW provide people with a sense of temporal coherence identity would be a useful area to consider further. Overall, the sustainability of HPW is under-researched, particularly in areas linked to the impact upon employee-employers, the use of strategic governance to facilitate HPW or indeed the failure of HPW. Focused work in these areas would contribute to our understanding of employee-employer relationships, what makes HPW effective, alongside providing a better understanding of the economic impact of HPW within the wider economy.

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FIGURE 1

The team concourse
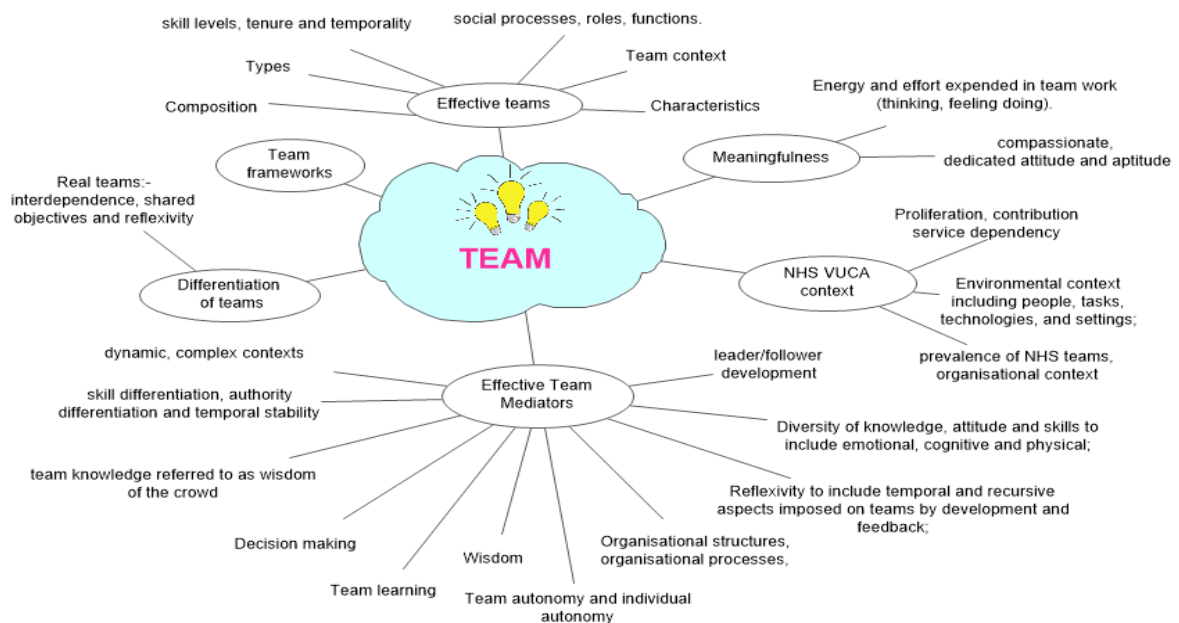
TABLE 1

Q-Set 44 validated statement

1	My team identity is a source of great pride
2	My positive sense of wellbeing is a result of being part of my team
3	Decision making is a shared team responsibility
4	Hard work and integrity are equally important in our team
5	Positive recognition is common within our team
6	The team is much bigger than the individuals within it
7	It is important to selection and retain good team players
8	Learning is actively encouraged by our managers and their managers
9	We are encouraged to aspire and innovate within the team
10	Attention to the little things make a big difference in our team
11	The sense of belonging I get from my team is really important
12	We feel we have a good level of control within our day to day work
13	I feel energised by my job and enjoy being part of the team
14	Being part of the team gives me energy and pride
15	Competence and knowledge are essential for our team success
16	Becoming an expert is essential in our team
17	There is a high level of trust within our team
18	Our team knows what needs to be done, how it needs to be done and by when
19	The organisations leadership supports us if we need to access learning which is essential
20	We have equal voices and are listened to, and respecting each other is vital
21	We know how to get things done and we can influence across levels and functions
22	If we make mistakes, we are not afraid of failure, we use it to reflect on and learn from
23	We feel that our managers care and listen and want us to achieve in our team
24	Challenge within the team is a healthy part of the decision making process
25	Credibility of our teams service comes from us maintaining high levels of expertise
26	We have access to and actively learn from our wider networks. We actively build these networks.
27	Flexibility in working and learning are integral to our success
28	We are all part of the teams planning processes which makes a difference
29	We stay motivated by continually improving – Change is our norm and is nurtured
30	Our team has high levels of energy which helps keep us at our best
31	I am in my element in my job – that is really important – it gives my lots of energy
32	We are clear and comfortable that we know how to achieve our targets and indicators
33	Our team always aims to go above and beyond what is the organisations expectations
34	People trust in our service which helps the service succeed and motivates us to do our best

35	Within the team we feel that we have a voice, are listened to and can make a difference
36	Team leaders actively encourage us to contribute – working together is core to our team
37	We support each other through adversity because we care for our team
38	We confidently use the governance arrangement to engage in continuous improvements
39	We are aware of our boundaries and clear of our expertise; though will go beyond these to give a good experience for the patient
40	It is important that we understand how we contribute to the patient, the team and our organisation and the local health system
42	We actively innovate and are confident in managing the associated risk to improve our service
42	It is important that we know how we are performing and supportive feedback is important
43	Learning opportunities and training are made available when needed and make a difference to me, the patient and how I feel about the organisation
44	We actively learn from each other - Coaching and mentoring inter- and intra-team are common practice and an essential component for continuous improvement

Source: Primary Data

TABLE 2

Demographic Data

CATEGORY	PROFILE
Gender	92% female; 8% male
Age	17% <30; 26% 30-40; 25% 40-50; 18% 50-60; 14% >60
Job grade	Grade 3 (junior administration) to Grade 9 (management)
Teams	Domiciliary services; theatre services; day care teams; 24 hour teams; support teams
Education	Academic qualifications; In-house qualifications; Professional qualifications.
Support	Supervision; coaching; peer-to-peer support; quality circles; reviews of practice
Years in the organization	5% <2 years; 46% 2-5 years; 32% 5-10 years; 17% > 10 years

Source: Primary Data

TABLE 3

Emergent Factors

FACTOR	UNDERPINNING STATEMENTS
Factor One - Supportive learning team: • The learning team • The expert team • The emotionally intelligent team	1. We are aware of our boundaries and clear on our expertise, though will go beyond these to give the patient a good experience. 2. Our team knows what needs to be done, how it needs to be done and by when. 3. Our team always aims to go above and beyond what is the organizations expectations. 4. My positive sense of well-being is as a result of being part of my team. 5. We have access to, and actively learn from, our wider networks. We actively build these networks. 6. The organizations leadership supports us if we need to access learning which is essential. 7. Becoming an expert is essential in our team. 8. We all 'pull our weight' in the team – this shows mutual respect.
Factor Two - Shared community: • Organizational citizenship	9. Learning opportunities and training are made available when needed and made a difference to me, the patient and how I feel about the organization.

• Discretionary behavior • Patient wellbeing • Innovation through governance	10. There is a high level of trust within our team. 11. We are encouraged to aspire and innovate within the team. 12. We stay motivated by continually improving. Change is our norm and is nurtured. 13. We confidently use the governance arrangement to engage in continuous improvements. 14. We actively innovate and are confident in managing the associated risk to improve our service.
Factor Three - Supportive learning system: • Team learning • Knowledge management	15. Learning opportunities and training are made available when needed and make a difference to me, the patient and how I feel about the organization. 16. Team leaders actively encourage us to contribute; working together is core to our team. 17. Learning is actively encouraged by our managers and their managers. 18. We actively learn from each other. Coaching and mentoring inter- and intra-team are common practice and an essential component for continuous improvement. 19. I feel energized by my job and enjoy being part of the team. There is a high level of trust within our team.

Factor Four - Getting better together • Synergy • Congruence	20. I gain confidence from being a discipline expert in my field within my team. 21. Hard work and integrity are equally important in our team. 22. The team is much bigger than the individuals within it. 23. Credibility of our team's service comes from us maintaining high levels of expertise. 24. We feel we have a good level of control within our day-to-day work. 25. The sense of belonging I get from my team is really important.
Factor Five - Employment relationship synergy: • Positive practices • Positive engagement	26. It is important that we understand how we contribute to the patient, the team and our organization and the local health system. 27. I am in my element in my job – that is really important, it gives me lots of energy. 28. The sense of belonging I get from my team is really important. 29. Credibility of our team's service comes from us maintaining high levels of expertise. 30. Hard work and integrity are equally important in our team.
Factor Six -	31. My positive sense of wellbeing is a result of

Courageous followership: • Courageous followership	being part of my team. 32. Challenge within the team is a healthy part of the decision making process. 33. We are clear and comfortable that we know how to achieve our targets and indicators.
Factor Seven - Getting better together: • Identity • Team expertise identity	34. We support each other through adversity because we care for our team. 35. My team identity is a source of great pride. 36. I am in my element in my job; that is really important as it gives me lots of energy. 37. Positive recognition is common within our team.
Factor Eight - Courageous leadership: • Wisdom of the crowds • Courageous leaders as shapers	38. We feel that our managers care and listen and want us to achieve in our team. 39. There is a high level of trust within our team. 40. Our team has high levels of energy which helps keep us at our best. 41. Competence and knowledge are essential for our team success.

Source: Primary Data