Effective top teams: luxury or necessity?

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This is the third in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson

Case study

At a Medical Advisory Committee meeting in 1987 the consultant in accident and emergency proposed that, in the light of a recent report by the Royal College of Physicians criticising the standard of cardiopulmonary resuscitation (CPR) in hospitals,¹ our district general hospital should review its training and procedures in CPR. The meeting agreed to form a subcommittee under the aegis of the consultant anaesthetist in charge of the intensive therapy unit. Other members were to be the proposer, the consultant responsible for the coronary care unit, that unit's sister in charge, and a junior doctor. Also included was the senior operating department assistant because he and his colleagues were important members of the crash team bringing the crash trolley and performing intubation. The subcommittee chairman obtained advice from a regional cardiac centre that had already revised its CPR training and procedures.

The subcommittee duly met. Its members were defensive of their various roles and departments, there was an acrimonious clash of personalities between consultants, and the meeting broke up having achieved nothing.

No further attempt was made to pursue the issue until 1991, by which time the district general hospital had

become an NHS trust. One of the trust's early decisions was to develop a resuscitation policy to include procedures and training. The task was allocated to the medical director, who delegated it to the clinical director of anaesthetics, whose directorate included operating theatres. This anaesthetist became the chair of a new working party on CPR. He was advised to limit the working party to four consultants, two of whom had been on the previous subcommittee. He was also advised to seek opinions from relevant experts within and, if necessary, outside the hospital.

Initially, he approached members and experts individually to indicate those aspects on which they should contribute a brief written submission. He amalgamated these into a draft report which was circulated in advance of the working party's meeting. At that meeting, each member was encouraged to comment on the report in general and on the section relating to their own special interest. Members were guided back to their remit if they digressed inappropriately. Agreement on the framework of a final draft was reached in just over one hour. The trust now has a modern resuscitation policy with built in outcome review.

Learning points

TEAM FAILURE

In 1987 the failure of the team was due to:

- The formation of the team as a result of the reactive response of the Medical Advisory Committee, rather than a proactive initiative
- The lack of clear mandate or direct recommendations to the team
- The inability to lead the team from a corporate perspective, so that although the team was composed of all the relevant internal experts, the players concerned ended up defending their departments and traditional roles in terms of providing a resuscitation service
- Lack of preparedness, which included no objective advice being offered to the chair. He could therefore incorporate only those aspects that suited his viewpoint, thus creating a suspicion of bias
- The individualistic nature of the key players, especially the consultants, which led to an uncomfortable clash of personalities.

TEAM SUCCESS

In 1992 the more successful impact made by the team was due to:

- A clear proactive decision taken by the trust, subject to internal market forces, to provide a quality resuscitation service
- The effectiveness and authority of the team in terms of its size and cohesion by having only four senior consultants
- The advice received by the chair, this time focusing on procedure, principally in terms of the need to call on other expertise, such as resuscitation staff, from all levels
- Greater ownership of the project, with members of the team producing written submissions
- The overall effectiveness of meetings, because of

good preparation, prior communication of draft documents, and firm but sympathetic adherence to the agenda.

Is the situation outlined in 1987 in the case study example untypical of the NHS or, more broadly, of organisations from both the private and public sectors? The answer is an emphatic no. Extensive survey work shows that the norm is that uncomfortable team dynamics and ineffective behaviour at the top of the organisation are prevalent not only in Britain but also in most other European countries (box).²

That does not alter the fact that teams are vital. Without effective top teams an organisation cannot function efficiently. Teams are the prime mechanism for both the consideration and implementation of policies and strategies. Senior executives need a forum in which to discuss the fundamental issues that face the organisation and identify and agree to implement approaches that will address current and future concerns and challenges.

Trends from the Cranfield Executive Development Survey in the United Kingdom and Ireland

- 40% of general managers feel negative about their senior bosses in the senior team
- 58% of chairs, chief executive officers, and managing directors feel uncomfortable about the effectiveness of the senior team and the performance of its members
- 51% of chief executive officers, managing directors, and general managers feel there are important and sensitive issues at top level which remain unaddressed
- 63% of senior management recognise that there are substantial hindrances to achieving objectives in the senior team

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However, if the members of the top management group feel that the quality of relationships, the ability to reach decisions, the commitment to the decisions reached, and the will to implement the decisions made is lacking then unfortunately there will be a gulf between what ought to happen and what actually does happen. If the quality of dialogue among the members of the senior executive is more negative or overly sensitive then the issues facing the team and the organisation may be only too well understood by the members of the senior team, but their relationships will be so strained that concerns about the organisation (and potential solutions to problems) may be unable to surface, because the discomfort generated in doing so would be too much for any one of them to bear. This makes for a bad and ineffective team.

Shaping the team

Shaping the team is critical to shaping the future, and involves not only understanding and appropriately shaping a potentially demanding and disparate group of people into a cohesive whole, but also recognising how the top team directly affects the overall business.

To create an effective team at the top is entirely in the hands of the members of the top management of the organisation. Five factors should be considered:

- A need for a key forum for dialogue
- Each member of the team needs to get on well with one another
- Positive executive relationships
- The way that issues, be they sensitive or not, are addressed
- Effective management styles and philosophy.

The difference between an effective team and an ineffective team is not that a fundamental compatibility exists among the members of the first, but that serious consideration has been given as to how the personalities in the senior team interrelate. In an effective team attempts have been made to create an environment conducive to generating a meaningful discussion about the business. This may involve inducing a certain amount of tension in the group, but not to the point at which it undermines cohesion. The 1991 attempt to improve the standard of cardiopulmonary resuscitation in the case study involved generating a far more positive dialogue, in terms of preparation for meetings, documentation, and honest and open conversation.

Those executives who do not seriously consider the impact of the interrelationships of the personalities in the top team are also not likely to have thought about the impact they themselves make on the group in terms of stimulating positive relationships or creating an open culture. They also tend to react just to their colleagues in the team. The ones who have considered their impact on their team colleagues have attempted seriously to adjust their approach to adopt both a style and a philosophy conducive to the team and the business.

Meaningful research

What, then, is required for health service organisations in terms of senior management performance, especially now that forces such as internal markets have been created? The question that needs to be addressed is, what needs to be done to make health service structures perform more effectively?

Consideration needs to be given to the following areas of research:

- Executive competency of the key senior executive roles represented on the NHS trust boards

Key point summary

- Teams are an essential component of the new organisational structure
- Relationships between key personalities can make or break a team; an understanding of these dynamics is imperative
- Teams often fail because they lack a clear mandate and a corporate perspective
- Teams succeed when they are proactive, well prepared, and communicate well
- It is essential that a forum for open and frank discussion is actively promoted
- A team's effectiveness needs to be assessed regularly

- The effectiveness of the newly established structures, how the key internal interfaces are being managed and whether those issues and concerns are being addressed, and the subsequent impact on quality of service provision

- The external interface between regional health authorities, district health authorities, and general practitioner fundholders, and their impact on the management and effective service delivery of trusts.

Effective decision making

Understanding the quality of dialogue at both key internal and external interfaces within NHS trusts will provide valuable clues to the effectiveness of decision making and implementation of policy. If a continuum were to be drawn which identified the key influences on decision making, at one end would be logic and at the other end emotions and personalities.

Decisions based on logic identify business and economic trends using data. A process of extrapolation allows decisions to be made. The interplay of personalities at the senior management levels means that decisions are driven by emotions. Who influences whom, who was the last one to see the boss after the meeting, and the overall mix of chemistries between personalities can all seriously influence the nature of the decisions made and the way in which they are implemented.

A full appreciation of the nature of the internal markets and the qualities required of senior management to address sensitive internal and external interfaces, and the desired dynamics of effective top teams, means that the effective senior manager should be able to reach a balanced view. In other words, open dialogue about the business and awareness of the personalities and relationships concerned, to ensure that commitment on decisions is reached, provides the basis for taking action with the insights and expertise already in existence within the senior team. Without such dialogue the potential of staff and management could be seriously compromised. The question is, will senior management teams rise to the challenge?

1 Report of the Royal College of Physicians. Resuscitation from cardiopulmonary arrest—training and organisation. *J R Coll Physicians Lond* 1987;21:175-82.

2 Kakabadse A. *Wealth creators*. London: Kogan Page, 1992.

"Every Doctor is a Manager" is a conference being run by the BMJ, BMA, and British Association of Medical Managers to explore the issues around doctors in management. It takes place on 16 February 1994 in London; details from the BMA Conference Unit, BMA House, Tavistock Square, London WC1H 9JR. Tel: 0171 383 6605.