# Daring to Dream: Learning the Lessons of Leadership for Service Improvement in Mental Health Services

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## Abstract

This paper presents nine key considerations for improvement in health and social care drawn from recent national and international experience and describes the ways in which some of these ideas are being incorporated into local whole systems intervention.

## Key words

service improvement; mental health; leadership; health and social care

## Introduction

In 2005 the new NHS Institute for Innovation and Improvement was formed replacing the role of the Modernisation Agency as a resource for local leadership development and service improvement. It stressed its intention to focus on only a limited range of priorities and as yet these do not appear to have included social care (see www.institute.nhs.uk). Over the same period the Care Services Improvement Partnership (CSIP) has emerged as an umbrella organisation encompassing service development and improvement agencies for people with mental health problems and learning difficulties across the age ranges.

The Modernisation Agency was strongly influenced by the international work of the Institute of Healthcare Improvement based in Cambridge Massachusetts in the US, and in particular the 'Pursuing Perfection' (P2) framework that was implemented from 2001 with support from the Robert Wood Johnson Foundation. This programme, which was reformulated and piloted in the UK (latterly as the 'No Needless Framework'; Bibby, 2004), represented the culmination of an impressive body of international experience of service improvement, including consideration of those practices that are likely to maximise the possibility that improvement initiatives will fulfil positive expectations (Reinertsen *et al*, 2004). The nine considerations below draw on that body of experience and the evaluations of service improvement initiatives here in the UK and in the US, citing published evidence where available.

 

## 1. Work from strengths

It is notable how the positive practice required when working face-to-face with people is echoed when trying to achieve organisational or systems change. Often practitioners, users and carers know more than they *know that they know* about organisational and systems development. This is a significant strength for us to be drawing upon.

At practice level a 'strengths' approach that emphasises the practitioners' role in bringing to the fore user's talents, experience and other positive qualities as resources for improvement has been recognised as positive practice for some time (Onyett, 2002; Ryan & Morgan, 2004). Key components of solutions-focused therapy and the positive affective tone that practitioners bring to bear have found application in approaches to organisational change (Jackson & McKergow, 2002). Appreciative Inquiry similarly seeks to explore and reveal the positive core of an organisation; the best in people and the world around them. David Cooperrider, the founder of Appreciative Inquiry stresses how this can feel like swimming against a strong cultural tide: *'… the whole of postmodern society is living within an internal dialogue or cognitive environment of a universal, diffuse, cynicism... at both the personal and institutional levels, throughout our society there is a widespread disturbance of vitality, a bleakening of the life feeling, a farewell to defeated idealisms, and a sense of paralyzing resentment'* (Cooperrider, 1999). This chimes with the experience of undertaking improvement work and is an issue that needs to be directly addressed. The authors go on to note that words like 'Utopian' have come to be negatively connoted yet all major social changes have sprung from a idealised vision (eg. parliamentary democracy, universal suffrage, the trade union movement).

A key principle of Appreciative Inquiry is that human systems move in the direction of that which they study. For this reason it is important to frame objectives as the achievement of positive improvements rather than just rectifying deficits. This helps participants in change to feel that they are part of an important social project that has personal meaning for them – they need to be encouraged to dare to dream. It also creates a virtuous cycle. As Cooperrider observes *'The Power of Appreciation ...rests with its self-reinforcing and self-generative capacity'* (Cooperrider, 1999).

A position statement on clinical leadership stresses that *'it is the quality of the relationship between leader and follower than matters most to performance-relevant attitudes and behaviour'* (Millward & Bryan, 2005). In contrast to deficit-based approaches to organisational development, such as inquiries and root-cause analysis, working appreciatively builds relationships thereby developing collective intelligence and improvement capacity. In contrast approaches that are characterised by lamentation and blame create weakened relationships and defensiveness. Perhaps most importantly an appreciative or solutions-focused approach brings a positive vision of the future into the present rather than bringing the past into the future.

## 2. Establish a system-level vision for improvement with ambition and commitment

Cooperrider observed that *'When it comes to understanding organisational existence from the perspective of human action, there is no better clue to a system's overall well-being than its guiding image of the future'* (Cooperrider, 1999). Clarity of vision and objectives is the *sine qua non* of

 

**Table 1:** A reformulation of the 'No Needless' Framework for mental health services

| 'No Needless' Framework | Promises to service users |
|---|---|
| No pain – including emotional pain | We will do everything we can to relieve your pain and suffering, including providing those interventions that are known to be most effective. |
| No needless death or disease | We will do everything we can to protect you from sources of harm that you cannot control.<br>We will provide you with the best medical interventions available.<br>We will not neglect your physical health just because you have a psychiatric diagnosis. |
| No feelings of helplessness – amongst staff or service users | We will inform, involve and empower you and everyone involved in your care… |
| No unwanted delay | We will respond to your needs and aspirations quickly… |
| No waste | We will make the best use of what we have, including the strengths you bring… |
| No inequality in service delivery | … whoever you are. |

organisational development and effective teamworking (West & Markiewicz, 2004). However, how that vision is articulated and subsequently internalised by those responsible for delivering care is critical. The P2 programme stressed developing transformational goals that connect with the values that brought people into health and social care in the first place, with externally imposed targets assuming only a secondary significance, and leaders being seen to personally commit to these aims. In practice, this means taking a stand and framing ambitious objectives as promises to users and the people that support them. It was this element that gave rise to the interpretation of P2 as the 'No Needless' framework[1] (Bibby, 2004). ***Table 1*** adapts that framework with mental health services in mind. ***Table 2*** develops this by exploring how promises might be derived through locally expressed needs and aspirations.

Although framing objectives as promises for users can provoke anxiety for those involved in change it is more in tune with the increasing outcome-based orientation of performance management and more powerfully connects with most practitioner's core desire to contribute to positive outcomes for the people that they are involved with.

## A story about the power of stories

Ambition, personal commitment and effective engagement of people's hearts and minds through telling a personal story was key to the emergence of early intervention in psychosis as a policy priority for mental health service development. It was the story of one man's anger and anxiety about the way his 16-year-old daughter was being treated for schizophrenia in 1993, the subsequent support he got from her psychiatrist and the regional mental health lead, how that led to him being able to make sense of her experience and then positively influence local and subsequently national services (including specific national targets and funding and the adoption by the World Health Organisation of an international declaration

[1] Further information on P2 is available through www.ihi.org/IHI/Topics/LeadingSystemImprovement/ and the Leading Improvement Leaders Guides. All the guides are available on www.institute.nhs.uk as is the NHS Sustainability Model and Guide. CSIP's Directory of Service Improvement also provides invaluable sources for practical tools and techniques for service improvement –www.csip.org.uk/Serviceimprovementdirectory

 

**Table 2:** Finding more local expression of objectives framed as promises to users

| Users' needs and wants | Promise |
|---|---|
| I want to be involved in my own care planning. | Your care planning session will be attended by you and the people you know need to be there. The care plan will be signed by you to indicate your involvement. |
| I want to be seen as a whole person not just an illness. | Assessments and care plans will cover all the areas of your life that are meaningful and important to you. You will be able to control what is looked at and be given information telling you what you should expect. |
| I want to be confident that I have had the best care and treatment. | Your care and treatment will be evidence-based. It will be delivered by enthusiastic and skilled staff. |
| I don't want to be admitted unless absolutely necessary. | You will be offered services at home of the same intensity and skill as you would in an acute ward. |
| I don't want poor communication, duplication or to have to tell my story again and again. I just want the help I need. | Your clearly written and agreed care plan will always follow you wherever you go and in particular at where care is transferred from one team to another (eg. at discharge from in-patient care). |
| I don't want to be made to feel worse. | You will be cared for in places that are clean and tidy, and where you and your specific cultural needs are treated with respect and consideration. |

of standards). This example exemplifies the importance of leaders taking a stand and demanding improvement from others. Drama and storytelling continue to be powerful media for winning commitment to the implementation of early intervention services at a local level.

## 3. Be courageous with participation

'Whole systems thinking' will always be something of a misnomer in that for some participants the whole system that they define as relevant may assume literally cosmic proportions. Nonetheless it is important to be as inclusive and ambitious as practically possible when defining the system of individuals and groups to involve in improvement. Iles and Sutherland described whole systems thinking as *'… [emphasising] the need to develop shared values, purposes and practices within and between organisations, and [using] large group interventions to bring together the perspectives of a wide range of stakeholders across a wider system'* (Iles & Sutherland, 2001). It is therefore imperative to be ambitious in bringing together those participants who have some significant interdependence on each other in the task of achieving valued outcomes using interventions that promote clarity of purpose and effective participation.

Uppermost is the challenge of establishing the authentic participation of users and the people that support them. Methods such as user-focused monitoring (Rose, 2001), process mapping, and storytelling are invaluable in giving a wide range of stakeholders a shared experience of the current experience of users. However participation needs to go beyond just providing a commentary. Users and their supports (eg. family and friends) need to be involved in the whole quality improvement cycle: defining and

  

describing the current situation, setting goals for improvement, taking action for improvement and making value judgements about whether what has been achieved is good enough.

Leaders are also not likely to achieve system-level improvement without the enthusiasm, knowledge, cultural clout and personal leadership of practitioners. As Reinertsen *et al* (2004) observe from their experience of P2 this is often not about engaging practitioners in the quality improvement work of the organisations but involving the organisation in the quality improvement work of the practitioners. Experience from P2 also highlights that *'The translation between quality improvement and business performance is weakly made in most health care organisations'* (Reinertsen *et al*, 2004), and that engaging the finance director as a champion for quality improvement is key to success.

Supporting individuals in finding a voice among a diverse range of stakeholders with different access to power and authority requires creativity in establishing tools for communication and honest and transparent leadership of a process that makes shared (and non-shared) objectives explicit and the power relationships that are in play clear and managed. This is the work of a cross-community leadership group.

## 4. Have the right team leading and leading effectively

On the basis of the Institute of Healthcare's extensive work on improvement, Reinertsen *et al* concluded that *'The most common reason for failure of large systems to change is the failure of the senior leadership team to function as an effective team with the right balance of skills, healthy relationships, and deep personal commitment to the achievement of the goals'* (Reinertsen *et al*, 2004: 3). When the job of mental health services is to promote, for example, social inclusion and race equality what is the cross-community leadership team that you would need to get the job done? Similarly, how will it achieve the required integration of vision and activity both horizontally across the statutory and voluntary sectors, organisations and individual stakeholders, and vertically across hierarchical tiers within the organisation such that the top team's work in influencing strategy and culture connects with the experience, aims and aspirations of people using the service?

Within an organisation, vertical integration can be promoted by effective leadership but only where basic human resource practices, such as effective appraisal and staff support, are in place. Bolden's (2004) review of the impact of leadership concluded that, *'At an organisational level, management and leadership appear to have an effect on a range of outcomes, but only as part of a more general set of [human resource management] practices ... It is the leader's influence on employee motivation and commitment that appears to have the greatest impact, rather than any specific characteristic or behaviour of the leader per se'* (Bolden, 2004: 23). There is therefore a need to see leadership in an organisational context as an enabler of optimal staff performance, building from the best values that they bring to their work, and shaped by the needs of the prevailing circumstances.

Horizontal integration requires effective practices for community engagement, such as those used in work with black and minority ethnic communities concerning drug use, mental health and regeneration by the University of Central Lancashire's Centre for Ethnicity and Health (www.uclan.ac.uk/facs/health/ethnicity/index.htm). Leadership from within statutory organisations is



 

also important in this context. Experience of P2 also stressed the role of these top teams as providing the authority to grant formal permission for people to operate outside their normal roles and workplaces and selecting local project areas as learning opportunities for the whole system.

Reinertsen *et al* (2004) stressed that *'The currency of leadership is attention'.* This attention needs to be channelled to processes for system-level improvement, and in particular the reporting of performance data at the highest levels of governance within the participating organisations. This needs to link to processes for monitoring the plan and revising it if progress is not far or fast enough.

Channelling leadership attention also requires organisational and project management skills that are often considered as the realm of management rather than leadership. Improvement work needs to be organised so that everyone knows their contribution to the overall system aims. Processes such as meeting agendas, performance measurement and supervision and appraisal systems need to be aligned to the system goals. This requires a credible and resourced plan translated into project work and other actions for leaders at all levels throughout the system.

## 5. Decide to build effective teams

The fact that health and social care is essentially a team-based activity would not be apparent from the attention given to teamwork development skills in pre-qualifying training. The kinds of leadership and improvement behaviours described above require inclusion of the right range of participants, their effective participation and good communication. Indeed almost everything that is described in this paper would be enacted in a team context.

The Aston Group has highlighted a range of positive outcomes between effective teamworking in health and social care settings including more effectiveness and innovation, improved mental health of staff and associations with improvements in key outcomes, including patient mortality (West & Spendlove, 2005). Effective teams have clear aims that are shared among team members, the minimum number of team members required to achieve these aims, good participation in decision making, an expectation of excellence and both rhetorical and practical support for innovation (West & Markiewicz, 2004). Unfortunately it appears that effective teamworking is far from the norm in health and social care delivery.

The Healthcare Commission's 2005 NHS National Staff Survey (Healthcare Commission, 2006) revealed that 89% of staff responded positively when asked: 'Do you work in a team?' However this shrunk to only 41% 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.

It is notable that many of the features regarded as key to effective leadership translate readily into the conditions necessary for effective teamworking (Onyett, 2004; 2003). Indeed effective teamworking itself can be regarded as a leadership process in that it provides direction and sense-making. Individual's roles as leaders can only be defined in terms of their relationship to others in the group in the role as followers. This is the root of much conflict in the team. For example if a person in the team has formally-recognised authority through their job description but they feel no sense of agency in the

 

role because key people in the team choose not to follow them, or specifically voice dissent about their way of formulating the team task (eg. a consultant psychiatrist whose model of care is at odds with the rest of the team). Borril *et al* (2000) found that lack of team leadership or conflict about leadership was associated with more ineffective teamworking in healthcare settings. There is therefore a clear incentive to consciously design teams and leadership roles to support them to be effective, making the best use of the evidence available. CSIP initiatives such as the 10 essential shared capabilities framework, guidance on new ways of working (eg. for psychiatrists) and the forthcoming Creating Capable Teams Approach (CCTA), are all key resources for helping in this process (see www.csip.org.uk/Serviceimprovementdirectory).

## 6. Do what works

We have described above how the most senior leaders in organisations need to operate well within their teams, while subscribing to a framework for improvement that builds on strengths and the meaning that people attach both to their dreams and current roles. However this will achieve little if not supported by tried-and-tested improvement science. There is evidence and considerable field experience testifying to the effectiveness of process-based improvement technologies such as process mapping (McLeod, 2005). However the application of improvement science and its embededdness within organisation culture will be subject to the leadership support that it draws from senior levels of the sponsoring organisation. The evidence on sustainability of improvement needs to be applied to promote the chances of enduring change, and frameworks now exist to help sites in doing this.

The development of the Effective Teamworking and Leadership in Mental Health Programme was based on recognition of the overlap between factors associated with good leadership and those that enhance teamworking (Onyett, 2002). It is an adaptable seven-day action learning-based programme for up to 21 people who are dependent on each other to achieve positive outcomes for a defined group of users. External evaluation (Rees & Shapiro, 2005) demonstrated the impact of the programme, particularly in the area of clarifying shared objectives and promoting effective participation. Participants appeared to particularly value being able to work on shared objectives by working across organisational boundaries through participation in action learning sets. P2 stressed the need for effective engagement of practitioners in improvement work and so another key feature of the programme is the deployment of models for improvement based upon clinical applications such as solutions-focused approaches (Jackson & McKergow, 2002) and taking a motivational interviewing approach to work with stakeholders (Rollnick *et al,* 1999).

## 7. Measure and monitor, collecting information on what matters

As described above, experience of P2 particularly stressed the need to establish measures of system-level performance that can be tracked at least monthly at the highest levels of governance within organisations. The 'Better Metrics' project (Crump & Whitty, 2005) and the work of the Healthcare Commission provides concrete guidance on how to achieve this though capacity to achieve this crucial aspect of improvement work within provider organisations remains a concern. Crump and Whitty cite Peter Fonagy and his colleagues on the need to embed data collection within an improvement process:

 

***'Collecting outcomes data alone has limited value, it is only when it is interpreted and translated into positive changes in practice that it will yield improvements in the quality of services. Skills in interpreting outcomes data have to evolve locally and require the active involvement and goodwill of all responsible for collecting and interpreting outcomes data within each local trust. Implementation of outcomes measurement should therefore follow a developmental path. Further, successful implementation requires a balance between setting minimal national standards while allowing sufficient flexibility to encourage local innovation and initiative.'***

## 8. Build collective understanding of what working in systems really means

All systems can be described with reference to their structure, process and culture. Within a system structures refer to the tangible elements. For example, with respect to the care programme approach this would include staff, record keeping forms, filing cabinets, ward and community teams. Process refers to acts like referral, assessment, communication with carers, using protocols and care planning. Culture has been defined as *'... a means of communication that offers both a template or guide to existing meanings that facilitate social interaction (eg. to render it intelligible and predictable) while at the same time furnishing a medium for reinvention and change through social interaction'* (Millward & Bryan, 2005). It is thus both how things are seen and 'how things are done around here'. For example, is the care programme approach a beneficent way of assisting users and their supporters to navigate complex systems of care, a way to codify and defend against risk in the interests of protecting staff, or the dead hand of bureaucracy pulling practitioners away from the serious business of building effective relationships with users? Arguably it is these perspectives on CPA that have determined the very variable implementation of the CPA since its inception in 1991[2].

Similarly while changes in structure often seem to work against local improvements by creating uncertainty and personal concerns about job security, organisational culture may influence the alacrity with which process-based improvement interventions are undertaken and embedded within organisational life. The effect of culture on performance in health and social care has been demonstrated (eg. Mannion *et al*, 2003) and those at the top of organisations have a key role in shaping it. Failure to understand this provides one aspect of why improvement efforts often fail to live up to our expectations. It also explains why leadership and service improvement need to be explored together. Leaders have a key role in creating the cultures in which improvement can flourish. For example, Durie *et al's* (2004) evaluation of a UK P2 pilot site highlighted the importance of: *'Leadership, demonstrating genuine commitment to aspirational goals, visible behaviour change, genuine commitment to the programme and to projects, and flexibility and comfort with ambiguity and emergence'* (see ***Table 3*** to see this in the context of their other key findings).

[2] A recent review found that still only 45% of users had a copy of the care plan under the care programme approach. See www.healthcarecommission.org.uk for further information.

 

**Table 3:** Principle conditions constituting receptive context for whole system transformational change (from Durie *et al*, 2004).

| |
|---|
| • Recognising that things are not working well enough, or could be done differently, with better outcomes for users. |
| • Leadership, demonstrating genuine commitment to aspirational goals, visible behaviour change, genuine commitment to the programme and to projects, and flexibility and comfort with ambiguity and emergence. |
| • Behaviour change and the reconfiguration of relations/creation of new relations. |
| • Culture of experimentation and supported risk-taking. |
| • Accepting the possibility that different ways of working and thinking will be better for users. |
| • Genuine and meaningful patient involvement. |
| • Language (including the challenge of professional language) and communication (between and within organisations). |
| • Pursuing perfection as a 'way of working'. |

The latter reflects the need for organisations to have great consciousness of important ways in which systems operate. Latterly this has had a high profile in organisational development literature but aside from some notable exceptions (eg. Chapman, 2004; Plsek & Greenhaigh, 2001) has had little airing among the wider workforce. This is perhaps because of the alienating language of complexity theory. With respect to mental health services some of the key features of complexity theory are:

**1.** Avoiding reliance on achieving change though pushing. As in the manner of allowing a tree to flourish the aim is rather to prepare the ground in order to maximise the possibility that growth will occur. The role of leaders is therefore to focus as much on those factors that will limit creativity (eg. time, poor user participation) as on those that promote it.

**2.** Rather than focusing on programmatic step-wise approaches to change that assume that participants will engage in a predictable way, the emphasis is on creating opportunities for creativity by giving space and time, not over specifying means and valuing experimentation, risk-taking and intuition. As Gosling and Mintzberg (2003) reflect, *'These days, what managers desperately need is to stop and think, to step back and reflect thoughtfully on their experience… events or 'happenings', become experience only after they have been reflected on thoughtfully'.*

**3.** Complex systems are inherently unpredictable, hence the need for tolerance of ambiguity and emergence referred to above. Small changes can have big effects and big changes very little effect. Tolerance of ambiguity includes the need to expect and manage polarities. Polarities are sets of opposites that can't function well independently. Because the two sides of the polarity are interdependent, you cannot chose one as a 'solution' and neglect the other. Examples of polarities might be working with 'whole systems' while achieving local focus, gatekeeping services while promoting ease of access, offering choice while prioritising the investment of resources, being an agent of social control while working to be user-centred.

 

## 9. Build improvement capacity

Creating a culture of improvement within organisations is a long-term project. Leaders must devote resources to establishing capable leaders of improvement throughout local systems. This network of leaders needs to be capable of rapidly recognising the need for improvement, and translating and locally implementing tried-and-tested approaches to improvement. CSIP has a key role in working with leaders, managers and human resources departments in supporting the development of improvement cultures. This will also include working to achieve effective partnerships with higher education. For example, the South West Peninsular Health Authority and the Peninsula Medical School developed a master's level 'Leading for Improvement' programme on improvement science. An aspiration of this programme is to build the capacity to continue to run the programme using programme graduates. It is aimed at improvement leaders be they practitioners or managers in both health and social care and primary and specialist care. Other national initiatives are also underway working to support service users in exercising their roles as leaders of local improvement and developing effective local leadership for community engagement and social inclusion. It is important that we capture the learning from these programmes to promote local improvement that makes a difference to users and those involved in supporting them.

## Conclusion

Relentless change, limited resources and increased expectations and uncertainty are endemic to modern health and social care. In this context it is easy to fall prey to a socially valued cynicism that, while making us appear streetwise and savvy, ultimately drains our spirit and our hope. Leaders have a social responsibility to counter this, making the best of their resources and in particular the qualities of their staff. They need to consciously work to uncover the positive spirit of organisation, the people within them and increasingly the wider communities of which they form a part. This in turn requires conscious effort to enrich the complex local systems of relationships that emanate from service users and their everyday sources of support. Nurturing positive relationships requires trust that in turn requires transparency, integrity and honesty. It also requires an environment where all stakeholders can fully maximise their creativity in the pursuit of improvement through good team design, objectives that have meaning for people, and a clear focus on outcomes that are properly evaluated and celebrated.

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### References

Bibby J (2004) *The 'No Needless Framework': Creating ambition in health and social care.* London: Modernisation Agency.

Bolden R (2004) *What is Leadership?* Leadership South West Research Report. Exeter: South West Development Agency. Available from: www.leadershipsouthwest.com.

Borril CS, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D & West MA (2000) *The Effectiveness of Healthcare Teams in the National Health Service.* Aston: Aston Centre for Health Service Organisation Research.

Chapman J (2004) *Systems Failure. Why governments must learn to think differently.* London: Demos.

 

Cooperrider D (1999) Positive image, positive action: the affirmative basis of organising. In: S Srivastva & D Cooperrider (1999) *Appreciative Management and Leadership* (Revised edition pp91–125). Euclid, OH: Lakeshore Communications.

Crump B & Whitty P (2005) *The Better Metrics Project.* Version 6. London: Office of the Strategic Health Authorities. Available from: www.osha.nhs.uk.

Durie RH, Wyatt KM, Fox M & Sweeney KG (2004) *Creating the Conditions for Transformational Change: An analysis of the initial stages of the Pursuing Perfection Programme from the perspective of complexity.* Report. Exeter: Health Complexities Group, Peninsula Medical School.

Gosling J & Mintzberg H (2003) The five minds of a manager. *Harvard Business Review* **1** November 54–63.

Healthcare Commission (2006) *National Survey of NHS Staff 2006.* Available from: www.healthcarecommission.org.uk.

Iles V & Sutherland K (2001) *Organisational Change.* London: National Co-ordinating Centre for NHS Service Delivery and Organisation. Available from: www.sdo.lshtm.ac.uk.

Jackson PZ & McKergow M (2002) *The Solutions Focus*. London: Nicholas Brealey Publishing.

Mannion R, Davies HTO & Marshall MN (2003) *Cultures for Performance in Health Care.* York: Centre for Health Economics, University of York.

McLeod H (2005) A review of the evidence on organisational development in healthcare. In: Peck E (Ed) *Organisational Development in Healthcare.* Oxford: Radcliffe.

Millward LJ & Bryan K (2005) Clinical leadership in health care: a position statement. *Leadership in Health Services* **18** (2) xiii–xxv.

Onyett SR (2002) Leadership for Change in Mental Health Services. *Mental Health Review* **7** (4) 20–23.

Onyett SR (2003) *Teamworking in Mental Health.* Basingstoke: Palgrave.

Onyett SR (2004) The joy of wading: leadership and teamworking in swampy conditions. *Mental Health Review* **9** (3) 35–41.

Plsek PE & Greenhaigh T (2001) The challenge of complexity in healthcare. *British Medical Journal* **323** 625–628.

Rees A & Shapiro D (2005) *Effective Teamworking and Leadership in Mental Health Programme. Evaluation Feedback Report to the NHS Leadership Centre.* Leeds: NHS Evaluation Group, University of Leeds.

Reinertsen JR, Pugh M, Bisognano M, Pearce J & Beasley C (2004) *What Will it Take to Move the Big Dots?* Briefing Paper. Cambridge, MA: Institute of Healthcare Improvement[1].

Rollnick S, Mason P & Butler C (1999) *Health Behaviour Change: A guide for practitioners.* Edinburgh: Churchill Livingstone.

Rose D (2001) *Users' Voices: The Perspectives of Mental Health Service Users on Community and Hospital Care.* London: The Sainsbury Centre for Mental Health.

Ryan P & Morgan S (2004) *Assertive Outreach: A Strengths Approach to Policy and Practice.* Edinburgh: Churchill Livingstone.

West MA & Markiewicz L (2004) *Building Team-based Working.* Oxford: BPS Blackwell.

West MA & Spendlove M (2005) The influence of teamworking. In: Cox J, King J, Hutchinson A & McAvoy P (Eds) *Understanding Doctors' Performance* (pp105–122). Oxford: Radcliffe.

 