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Leadership in interprofessional health and social care teams: a literature review

Tony Smith
Centre for Leadership in Health and Social Care, Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK

Sally Fowler-Davis
Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK

Susan Nancarrow
Southern Cross University, Lismore, Australia, and

Steven Mark Brian Ariss and Pam Enderby
School of Health and Related Research, University of Sheffield, Sheffield, UK

Abstract

Purpose – The purpose of this study is to review evidence on the nature of effective leadership in interprofessional health and social care teams.

Design/methodology/approach – A critical review and thematic synthesis of research literature conducted using systematic methods to identify and construct a framework to explain the available evidence about leadership in interprofessional health and social care teams.

Findings – Twenty-eight papers were reviewed and contributed to the framework for interprofessional leadership. Twelve themes emerged from the literature, the themes were: facilitate shared leadership; transformation and change; personal qualities; goal alignment; creativity and innovation; communication; team-building; leadership clarity; direction setting; external liaison; skill mix and diversity; clinical and contextual expertise. The discussion includes some comparative analysis with theories and themes in team management and team leadership.

Originality/value – This research identifies some of the characteristics of effective leadership of interprofessional health and social care teams. By capturing and synthesising the literature, it is clear that effective interprofessional health and social care team leadership requires a unique blend of knowledge and skills that support innovation and improvement. Further research is required to deepen the understanding of the degree to which team leadership results in better outcomes for both patients and teams.

Keywords Collaboration, Health care, Leadership, Teamwork, Interprofessional, Multiprofessional

Paper type Literature review

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Background

This paper reports on the results of a critical literature review (Grant and Booth, 2009) that aimed to evaluate the evidence and to present an analysis of leadership in interprofessional teams in health and social care organisations.

Concerns over leadership in the UK National Health Service (NHS) first became an area of focus in the late 1980s when professional management was introduced (Mackie, 1987). When the labour government came to power in 1997, leadership capacity was recognised as a critical factor in the reform agenda; to modernise the NHS (Goodwin, 2000). The Department of Health set up a National Centre for Leadership in 2001 as part of the NHS Modernisation Agency and this led to a plethora of leadership initiatives commissioned by NHS organisations that included public health (McAreavey *et al.* (2001), a range of leadership frameworks (Bolden *et al.*, 2003) and competency frameworks (Bolden *et al.*, 2006). For nearly two decades, leadership development has been a priority within health care but less attention has been given to the effectiveness of leadership on the outcomes of teams. Reports on health service failures at an organisational level have further regularly identified poor leadership as a contributory factor in criminally negligent care (Keogh, 2013; Francis, 2013; Berwick, 2013).

The Kings Fund (2011) has consistently calls for replacement of heroic leadership models which focus on the development individuals in favour of an increased focus on shared/collective leadership models and extension of leadership development efforts to all levels. The continuing erosion of professional divisions in intermediate care and particularly community services has been driven in part by the ambition to create integrated services has enabled health and social care professions to increasingly work together around discrete stages of patient pathways (Ovretveit, 1997; Pollard *et al.*, 2005, Means *et al.*, 2003).

The formation of interprofessional teams has brought the issue of leadership to the fore with the challenge of enabling sometimes large teams of different professionals and differently skilled workers to coordinate their efforts and work more closely together than was traditionally the case. This integration agenda is not straightforward, however, as it fundamentally contradicts many of the fundamental tenets of professionalism (Reeves *et al.*, 2010), with health-care leaders sharing responsibility across services, for the delivery and outcomes of care.

Thylefors *et al.* (2005) developed a useful taxonomy to understand the level of integration of work practices in health-care teams consisting of a range of professions/disciplines.

"Multiprofessional" teams have no focus on collective working. Professionals treat the patient independently, without the input of other team members. This model represents the customary form of health-care delivery in which doctors traditionally took responsibility for coordinating independent contributions to the care of patients.

Interprofessional working encapsulates the core notion of teamworking, where outputs are measured and based on the collective effort of team members working with the patient. Effective care is accomplished through the interactive efforts of health-care workers, with some responsibilities shared, requiring collective planning and decision-making (Day, 1981; Sicotte *et al.*, 2002).

A study of the effects of multiprofessional and interprofessional team approaches on teamwork; and team effectiveness for rehabilitation teams, found that interprofessional teams showed significantly better results for nearly all aspects of teamwork and team effectiveness measured (Korner, 2010).

This paper presents a review of leadership in interprofessional health and social care teams, seeking to identify elements that are characteristic of and/or associated with higher performance and achieving better patient outcomes.

Methods

Critical review is undertaken as a method for enabling new conceptual insights by seeking to embody existing or derive new theory from existing literature (Torraco, 2016). A potential difficulty with the approach is that the evaluation of contribution is dependent on the type of evidence. In management literature, publications about the topic may be small in quantity, of poor quality, and/or inconsistent in terms of both the application of methods and epistemology (Tranfield *et al.*, 2003).

In addition, systematic reviews in management literature need to relate directly to the context of health and social care (Easterby-Smith *et al.*, 2008) to be considered the best evidence available, even though these may not be rigorous experimental studies of the type normally conducted within the medical sciences and may even propose theory where no empirical evidence exists.

Review questions/objectives

The specific aim of the review was to describe facets of leadership within interprofessional health and social care teams and generate a thematic framework that explains and develops conceptual understanding of that role.

The review addresses the following key objectives:

- research and grey literature on interprofessional team leadership in health and social care, to appraise any key theoretical constructs and tested variables; and
- research and grey literature relating to interprofessional health and social care team working, commenting on interprofessional team leadership.

The search strategy was designed to access peer-reviewed, published studies for the period 1994–2015. This time period was determined as significant, based on the policy context i.e. Department of Health had begun to focus increasingly only patient pathways and interprofessional working to improve patient care (NHS Plan 2000 – www.nhshistory.net/nhsplan.pdf) and at the end of the period, the Five Year Forward View (NHS England, 2014) outlined and consolidated the ambition to commission and provide integrated health care with significant focus on the leadership of new services and ways of working (Ham and Murray, 2015) .

The peer-reviewed databases listed below in *Databases* were searched, together with governmental databases such as the Department of Health and the NIHR:

- ASSIA;
- CINAHL;
- Cochrane database of systematic reviews;
- Health management information consortium;
- EMBASE;
- ERIC;
- MEDLINE;
- PsycINFO;
- NIHR;
- NHS Confederation;
- Department of Health;
- King's Fund; and
- University of Sheffield, STAR library database.

A search using all identified relevant keywords and index terms (see Table I) was then undertaken across all included databases. Hand searching included reference lists of all identified reports and articles, which were screened to identify additional studies and relevant texts in the grey literature referring to interprofessional team leadership in health services. The search was then extended to include any identifiable reference to "team-working" and interdisciplinary, which were broader than interprofessional, to identify any mention of team leadership in a health context. An additional reason for the extension was in recognition of unqualified or non-professional staff who are part of the teams caring for and treating patients. Finally, the search terms identified a range of team and service outcome metrics that refer to the process of care and the impact of care typically using outcomes of service/team rather than health status or health outcome.

Table I below outlines the key search terms and Table II provides the terms used for the additional focus on potential outcomes of team leadership within the care context.

Inclusion and exclusion criteria

The critical review aims to develop an evidence-based theoretical understanding of interprofessional team leadership, including conceptual models for practice. It is based on empirical findings or narrative examples from practice, described and/or evaluated. Selection began with an initial screening of the papers by title and abstract using the specific decision rules to identify relevant papers. A set of decision criteria were developed; to identify relevant papers that would distinguish between leadership theories in health care and those particularly referring to interprofessional teams. The initial categories related to main methodology i.e. empirical study, qualitative research, or a narrative study, or systematic review. This method sorted papers and enabled authors to select key papers related to the review objectives and enhanced decisions about which papers to include or exclude (Paterson *et al.*, 2001). Further selection identified any papers including reference or outcomes achieved through interprofessional team leadership in health and social care. As there were few papers specifically on this topic, the search was extended to include papers on interprofessional teamwork, again allowing leadership to become the emerging narrative within publications on health care team practice. Owing to the dearth of literature on inter* (professional, disciplinary) team leadership publications discussing primary or secondary research on interdisciplinary team leadership, or interdisciplinary team working were included. Papers that had no apparent evidence base were excluded from the review and these included opinion pieces and editorials with particular views of a single author.

A mixed methods quality appraisal tool was then used to evaluate the selected empirical studies and this was also adapted and applied to the descriptions of teams and clinical practice context. Table III includes the quality assessment criteria used for the study. Evaluations of leadership or team outcomes and processes were included and the content re-viewed for satisfactory description and relevant content.

Interdisciplinary or interprofessional or multiprofessional or multidisciplinary or inter-disciplinary or inter-professional or co-operate* or multi-professional or multi-disciplinary or "inter disciplinary" or "inter professional" or "multi disciplinary" or "multi professional"	And	Team* [includes team, teams, team work, teamwork or team working]	And	Lead* (includes leads, leading, leader, leadership)	

Table I.
Key search terms for IpTL

Interdisciplinary or interprofessional or cooperate* or collaborate* or multidisciplinary or inter-disciplinary or inter-professional or co-operate* or multi-disciplinary or "inter disciplinary" or "inter professional" or "multi disciplinary"	And	Team* [includes team, teams, team work, teamwork or team working]	And	Lead* (includes leads, leading, leader, leadership)	And	Length of stay Patient admission Patient discharge Patient readmission Patient transfer Quality of health care Outcome and process assessment (health care) Outcome assessment (health care) Treatment outcome Treatment failure Mortality Cause of death Child mortality Fatal outcome Foetal mortality Hospital mortality Infant mortality Maternal mortality Perinatal mortality Survival rate

Table II.
Key search terms for outcomes of IpTL

Data extraction and synthesis

Data extraction was undertaken manually using an excel spreadsheet designed for the purpose of categorising findings. Papers were read and re-read as full text and emergent ideas were identified with key ideas and theories recognised and noted. The Ritchie and Spencer (1994) "Framework" approach was adopted to code the data and further analysis was undertaken using the findings from the selected reports (grey literature). This approach was chosen, because it was both rigorous and permitted the analysis of original data but was also open to adaptation and change; allowing methodical treatment of all similar units of analysis and some case comparisons. Principally it was adopted as a means of synthesis that allowed full review of the located data (Ritchie and Spencer, 1994). Following the coding of papers and data extraction into categories a number of preliminary themes were developed. These formed the basis of the framework that could then be used to create some broader, higher order themes and additional data were included, based on agreement with other authors. The framework was continually modified as a deeper understanding of the data was developed, as new data were coded and new themes emerged. The synthesis was completed when all data had been incorporated and items checked to ensure that the framework permitted a robust "container" for the data and permitted a more conceptual analysis of interprofessional leadership.

Results

Searches for Interprofessional Team (working and) Leadership identified a total of 634 texts and after supplementing these searches with relevant papers identified in the interprofessional teamworking literature review and back-chaining through reference lists,

	Screening questions	Yes	Cannot tell	No
1	Problem statement Does the statement of the phenomenon lead directly to the purpose of the study and the research questions?			
2	Purpose of the research Is the purpose of the research clearly expressed?			
3	Research questions Are the research questions explicitly expressed?			
Detailed questions				
4	Literature review Is the literature related to the research problem and point towards the research purpose?			
6	Sampling and participants Is there description of type of sampling procedure? Is there identification of inclusion criteria? Does the sample size and configuration fit the purpose and sampling strategy? Are features of the sample critical to the understanding of the findings described? Do sites of recruitment fit the evolving needs of the study?			
7	Data gathering strategies Is there clear description of data gathering procedures? Is there discussion of time frame of data gathering?			
8	Data management and analysis strategies Are methods used described? Is there identification of categories or common elements found?			
9	Findings Are interpretations of data demonstrably plausible and/or sufficiently substantiated with data? Are concepts or ideas well-developed and linked to each other? Are concepts used precisely? Is there provision of evidence as to how representative in the sample the various findings were?			
10	Conclusions, discussion, implications, suggestions for future study Does the discussion pertain to all significant findings? Do the interpretive statements correspond to the findings? Are the study findings linked to the findings of other studies or to other relevant literatures?			
11	Validity Is there evidence that researcher has considered the effect of his/her presence on the research findings? Is there evidence that researcher has considered possibility of research bias or misinterpretation? Are validation techniques used that fit the purpose, methods, sample, data and findings of the study?			

Table III.
Quality assessment criteria

1,419 papers were identified as being of possible interest. All papers contained a combination of the key words used in the search from published literature between 1994 to 2015.

Following full text screening, categorisation by methods to exclude opinion pieces and critical appraisal a total of twenty-eight papers were selected. These were deemed to provide an analysis of outcomes from team leadership and proposed conceptual frameworks of IpTL or discussed elements of IpTL in-depth.

The findings of the analysis of these papers is set out below and summarised in IpTL framework. Further explanation of the relevance of each category is also added below to explain the IpTL Framework:

(1) Facilitate shared leadership:
- consciously involve team members in, decision-making and delegate responsibilities appropriately (Day, 1981; McCallin, 1999; Wilson, 2001; Ovretveit, 1997; Mickan and Rodger, 2000; McCallin, 2003, Institute-for-innovation-and-improvement, 2010, Sicotte *et al.*, 2002; West *et al.*, 2003);
- empower team members (McCray, 2003);
- develop and maintain non-hierarchical structures (Ovretveit, 1997; Krueger, 1987);
- provide information the team requires (Mickan and Rodger, 2000);
- work to create agreement (Mickan and Rodger, 2000); and
- coach colleagues in shared leadership (McCallin, 2003; Maister, 1993).

(2) Transformation and change (McCray, 2003; Irizarry *et al.*, 1993):
- create a climate where staff are challenged, supported, motivated and rewarded (West *et al.*, 2003);
- respond to change flexibly (Suter *et al.*, 2007);
- facilitate or act as a catalyst for practice change (Willumsen, 2006);
- act as a role model (Pollard *et al.*, 2005; West *et al.*, 2014); and
- inspire other team members (West *et al.*, 2003).

(3) Personal qualities:
- enthusiasm (Pollard *et al.*, 2005);
- commitment (Abreu, 1997);
- empathy (McCray, 2003); and
- knowledge of people (Suter *et al.*, 2007).

(4) Goal alignment:
- ensure the team has articulated a clear and inspiring vision of its work (Lyubovnikova *et al.*, 2015);
- assure productivity and goals are in line with the organisation (Leathard and Cook, 2004);
- protect regular time for the team to review its performance (Lyubovnikova *et al.*, 2015); and
- provide feedback about important issues (Mickan and Rodger, 2000; Leathard and Cook, 2004).

(5) Creativity and innovation:
- establish a productive balance of harmony and debate to ensure creativity (Leathard and Cook, 2004);
- develop innovations and new practice models (Suter *et al.*, 2007); and
- ensure effective leadership and team work processes (West *et al.*, 2003).

(6) Communication:
- maintain clear communication channels and facilitate interaction processes (Ovretveit, 1997; Suter *et al.*, 2007; Willumsen, 2006; Blewett *et al.*, 2010);

- listen to, support and trust team members (Mickan and Rodger, 2000; Leathard and Cook, 2004);
- initiate constructive debates and share their own ideas (Mickan and Rodger, 2000; Lyubovnikova *et al.*, 2015); and
- manage conflict and maintain a productive balance between harmony and healthy debate (Mickan and Rodger, 2000; McCray, 2003).

(7) Team-building:

- set expectations for working together (Suter *et al.*, 2007);
- create a climate of mutual respect (Ovretveit, 1997; Leathard and Cook, 2004);
- ensure cohesion (Willumsen, 2006);
- develop the interpersonal skills of the team (Ovretveit, 1997);
- ensure the contextual socialisation of new/inexperienced team members (McCray, 2003);
- promote interprofessional collaboration (Suter *et al.*, 2007; McCallin, 2003; Branowicki *et al.*, 2001); and
- facilitate group reflection on practice (McCallin, 1999; Branowicki *et al.*, 2001).

(8) Leadership clarity:

- ensure clarity of leadership (Nancarrow *et al.*, 2009; West *et al.*, 2003); and
- combine strong leadership and high involvement (Rosen and Callaly, 2005).

(9) Direction setting:

- coordinate tasks (Mickan and Rodger, 2000);
- manage processes (Maister, 1993);
- ensure work is allocated work equally (Pollard *et al.*, 2005); and
- set clear tasks (Ross *et al.*, 2000).

(10) External liaison:

- represent the team externally (Irizarry *et al.*, 1993);
- ensure necessary resources (Maister, 1993);
- develop strategies for promoting the work of the team (Irizarry *et al.*, 1993);
- demonstrate effectiveness through data collection and evaluation (Irizarry *et al.*, 1993);
- ensure the team understands its customers and can exploit new opportunities (Willumsen, 2006); and
- develop networks and linkages(Pollard *et al.*, 2005).

(11) Skill mix and diversity:

- recruit externally and develop internally (Ross *et al.*, 2000);
- ensure regular supervision and PDR (Burton *et al.*, 2009); and
- assure access to relevant training (Burton *et al.*, 2009).

(12) Clinical and contextual expertise:

- high levels of professional expertise (Maister, 1993; Irizarry *et al.*, 1993; Branowicki *et al.*, 2001);
- demonstrate in-depth understanding of the organisation (Branowicki *et al.*, 2001) and current development programmes (West *et al.*, 2014);

- balance focus between the needs of the patient, organisation and team (Branowicki *et al.*, 2001);
- facilitate understanding of context and ensure all perspectives are taken into account (Abreu, 1997); and
- knowledge of the professional role of others (MacDonald *et al.*, 2010).

Facilitate shared leadership

For interprofessional teams to work effectively, each team member must accept responsibility as a member-leader stepping in and out of the leadership role when their professional expertise, particular knowledge of a client, or the situation comes to the fore (McCallin, 1999; Wilson, 2001).

This process requires a formal leader who has overall responsibility for the performance of the team, but consciously shares the leadership function facilitating joint decision-making and delegates leadership roles (Day, 1981; Sicotte *et al.*, 2002; Ovretveit, 1997; Mickan and Rodger, 2000; McCallin, 2003, Institute-for-innovation-and-improvement 2010, West *et al.*, 2003).

The key mechanism for achieving this is empowerment (McCray, 2003). The leader actively works to develop/maintain non-hierarchical, democratic structures (Ovretveit, 1997; Krueger, 1987). They coach team members (Maister, 1993) to develop the skills required (McCallin, 2003) share their ideas, work to create agreement and supply information the team requires (Mickan and Rodger, 2000).

Transformation and change

Transformational leadership is important (McCray, 2003; Irizarry *et al.*, 1993). The IpTL acts as a role model in line with their espoused values (Pollard *et al.*, 2005; West *et al.*, 2014) to create a climate in which staff are inspired (West *et al.*, 2003) challenged, supported, motivated and rewarded (Irizarry *et al.*, 1993); respond to change in a flexible way (Suter *et al.*, 2007); and facilitate or act as a catalyst for practice change (Willumsen, 2006).

Personal qualities

The IpTL must be able to show enthusiasm (Pollard *et al.*, 2005), commitment (Abreu, 1997), the ability to empathise (McCray, 2003) and knowledge of people (Suter *et al.*, 2007).

Goal alignment

The IpTL works to influence the direction and climate of the group to ensure goal alignment with the organisation and productivity (Leathard and Cook, 2004). They do this by ensuring the team has articulated a clear and inspiring vision of its work, creating regular times when it can review it's performance (Lyubovnikova *et al.*, 2015) providing feedback to highlight important issues (Mickan and Rodger, 2000; Leathard and Cook, 2004).

Creativity and innovation

A productive balance of harmony and debate is vital to ensure creativity (Leathard and Cook, 2004) and development of innovations and new practice models (Suter *et al.*, 2007). However, teamwork processes and team leadership have been found to consistently predict team innovation (West *et al.*, 2003).

Communication

The leader must facilitate the interaction processes and develop/sustain clear communication channels in the team (Ovretveit, 1997; Suter *et al.*, 2007; Willumsen, 2006; Blewett *et al.*, 2010). They do this by initiating constructive debates and modelling their own ideas (Mickan and Rodger, 2000; Lyubovnikova *et al.*, 2015) and supporting, listening to and trusting team members (Mickan and Rodger, 2000; Leathard and Cook, 2004).

The leader must also manage conflict, ensuring a productive balance between harmony and healthy debate (Mickan and Rodger, 2000; McCray, 2003).

Team-building

Teamwork is not a naturally occurring phenomenon (Lyubovnikova *et al.*, 2015). The team leader must therefore invest time in team-building, `setting expectations for working together (Suter *et al.*, 2007) and creating a climate of mutual respect (Ovretveit, 1997; Leathard and Cook, 2004). They work to ensure cohesion (Willumsen, 2006), developing the interpersonal skills of the team (Ovretveit, 1997) promoting interprofessional collaboration through group reflection (McCallin, 1999; Branowicki *et al.*, 2001) on practice and ensuring contextual socialisation of new or inexperienced team members (McCray, 2003).

Collaboration is promoted by allowing enough time for discussion and reflection on practice and encouraging staff to interact with those outside their profession (Suter *et al.*, 2007; McCallin, 2003; Branowicki *et al.*, 2001).

Leadership clarity

In spite of growing support for shared/collaborative/collective leadership models there is evidence to suggest that interprofessional teams need an overall team leader to operate effectively (McCallin, 2003).

A 2009 study found that teams with a specific team leader had higher levels of staff satisfaction than teams where the leadership role was split (Nancarrow *et al.*, 2009). Clarity of leadership is associated with clear team objectives, high levels of participation, commitment to excellence and support for innovation (West *et al.*, 2003). Primary health-care team members rated their effectiveness more highly when they had strong leadership and high involvement amongst team members (Rosen and Callaly, 2005).

Direction setting

The leader ensures that the team retains a focus on its priorities and goals and that individual team members maintain the correct focus (Mickan and Rodger, 2000). They work to manage team processes (Maister, 1993) including setting clear tasks (Ross *et al.*, 2000) coordinating work (Mickan and Rodger, 2000) and ensuring equitable allocation (Pollard *et al.*, 2005).

External liaison

The team leader must exercise external responsibility for the team (Irizarry *et al.*, 1993) ensuring that it is represented and gains the resources it requires (Maister, 1993). This requires: promoting the work of the team (Irizarry *et al.*, 1993) the ability to develop networks and linkages (Pollard *et al.*, 2005) demonstrating effectiveness through data collection and evaluation (Irizarry *et al.*, 1993) and adopting a marketing orientation to ensure the team understands its clients and can exploit new opportunities (Willumsen, 2006).

Skill mix and diversity

The team leader's role is to ensure that the team contains the right skill mix and diversity to achieve its goals and tasks. This involves both external recruitment and internal development (Ross *et al.*, 2000) with regular supervision, annual performance reviews and access to relevant training important factors (Burton *et al.*, 2009).

Clinical and contextual expertise

Professionals will only be accepted into IpTL roles if they prove their professional expertise (Maister, 1993; Irizarry *et al.*, 1993; Branowicki *et al.*, 2001). Knowledge of the professional role of others is also a key competency (MacDonald *et al.*, 2010). Within this, it is important that the team leader balances focus between the needs of the patient, organisation and team (Branowicki *et al.*, 2001). Understanding of the organisation's mission, structure, economics, politics (Branowicki *et al.*, 2001) and current development programmes (West *et al.*, 2014) together with a sound historical perspective, are also important to facilitate understanding of context and ensure all perspectives are taken into account (Abreu, 1997).

Discussion and conclusions

An IpTL framework in health care has been synthesised from the available published evidence and has been presented as a range of particular competencies that can be compared to the general management literature related to team management and leadership.

Many factors associated with better team leadership within management literature can also be seen in the IpTL framework. Both bodies of literature include a focus on: achieving organisational goals, managing performance, managing external relationships (boundary spanning activities) and demonstrating technical expertise (Larssen and LaFasto, 1989; Hackman, 1989; Stanniforth and West, 1995; LaFasto and Larssen, 2002; Hayes, 2002; Hackman, 2002; Katzenbach and Smith, 2003; Shackleton, 1995; Stoker, 2008; Burke *et al.*, 2006; Stoker, 2008).

In contrast, the IpTL framework specifically highlights a leadership function for the team and the review demonstrates that as well as maintaining the managerial function an interprofessional team requires a person who can promote transformation and change and support creativity and innovation as key elements of their role. Significantly, a meta-analysis by Burke *et al.* (2006) shows that transformational leadership behaviours, (often linked to change and innovation) can have a potent effect within teams. West *et al.* (2003) also found that teamwork and team leadership processes consistently predict innovation.

Empowerment appears as a primary focus in the generic team leadership literature as a mechanism for collaboration, but the focus in the IpTL literature is more on shared, collaborative or more recently collective (West *et al.*, 2014) leadership. Conceptually these factors are distinct, but in the ways they are described appear to have more similarities. The IpTL literature talks more about shared, collective and collaborative leadership, particularly in relationship to professionals within the teams. However, there is a paradox in that there is good evidence that clarity of leadership (West *et al.*, 2003; Nancarrow *et al.*, 2009) also appears to be important. Other commentators clarify, that shared leadership in IpT's is facilitated by the team leader (Krueger, 1987; Maister, 1993). It may be that shared or collective leadership are more palatable concept to professionals than empowerment as they lend more status to professional expertise and accommodate autonomy rather than challenge it.

The IpTL framework overtly mentions team building as a key activity of the team leader and the wider literature on team leadership also refers to the fact that it takes effort to

develop a team (Stanniforth and West, 1995; Hackman, 2002; Katzenbach and Smith, 2003). In the IpT literature, teamwork is still often an ideal that health and social care organisations are working to attain and a level of complexity is apparently which is to do with ensuring the correct mix and level of skills in the team. The IpTL literature focuses on developing the dynamics within the team as a whole and increasing integrated professional practice, with less attention paid to setting priorities and managing performance.

The literature review also raised some general questions about IpT's. There is consensus in teamwork literature that teams become less effective as they become larger. However, Nancarrow *et al.* (2009) found that larger interprofessional care teams providing intermediate and community care for older people produced better patient outcomes, in spite of less satisfaction amongst team members and higher intention to leave. It is not clear from these results whether there is a limit to this relationship, where the economies of scale and enhanced workforce flexibility delivered by larger services, becomes offset by the impact on teamworking? In a further study (Nancarrow *et al.*, 2013) comments on the difference between assumed shared decision-making and shared power across professions and the reality; perhaps alluding to the challenges of working across a large multi-professional context.

A second issue is that whilst many of the services that took part in this particular study were called teams, it is unclear how many operate as teams in practice. As already discussed, "team" is a term almost ubiquitously applied to work groups. Certainly, the size and structure of teams in this study are often outside the parameters put forward in the literature on teams. A final issue is the term interprofessional. There are increasing numbers of none professionally qualified staff in health care IpT's, however their role and function in the literature on interprofessional teamworking and leadership is totally absent. We would therefore propose that that interdisciplinary is a more suitable term to use as it is broader and inclusive of all team members.

What is different about IpTL in health care appears to be the unique context in which it is applied. The multiprofessional nature of the workforce in health, the public service setting, their function and the contexts that they operate within, make the dynamics in health care IpT's differ from the dynamics of teams in other settings. This difference seems to be highlighted by West *et al.* (2014) who advocate collective, distributed leadership practices for the NHS as a whole that resonate closely with the findings of this review.

Further, the literature does indicate that there are some elements of leadership practice, which may be particularly effective in interprofessional team settings. Perhaps the key issue highlighted is the fact that the operational workforce within health and social care is predominantly multi-professional in nature. Increasingly these professionals, together with other disciplines, are working together in a more integrated fashion. The creation of IpT's has therefore created a unique leadership context. Whereas traditionally professions would be functionally led (i.e. doctors by doctors, nurses by nurses) by a professional with recognised expertise, in IpT's, this functional leadership divisions are impossible to sustain. The leader can at most be only from one profession or discipline and therefore cannot therefore demonstrate greater professional expertise in other professions. This makes IpT leadership more demanding as the team leader, needs to find a way of leading a diverse professional workforce, without being able rely on professional credibility as a *locus* of authority. Further, the IpTL needs to be able to find ways to persuade an interprofessional group, to give up some professional autonomy, to integrate their practices and operate as a team.

Conclusion

This critical literature review examines how leaders of interprofessional teams are functioning and the synthesis identifies a framework of factors that contribute to good leadership practice. With a continuing paucity of empirical research data on IpTL, there is still much that is unknown about the IpTL process.

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About the authors

Dr Tony Smith is a Senior Lecturer, in Leadership and Organisation Development, at the Centre for Leadership in Health and Social Care, Sheffield Hallam University and has conducted research related to leadership in health and social care teams. Tony Smith is corresponding author and can be contacted at: t.smith@shu.ac.uk

Dr Sally Fowler-Davis is a Clinical Academic Researcher in the Centre for Health and Social Care Research, Sheffield Hallam University and Clinical Research Development Officer for the Combined Community and Acute Care Group at Sheffield Teaching Hospitals.

Susan Nancarrow is a Professor of Health Sciences and Chair of Academic Board at Southern Cross University, Australia. Susan is a Health Services Researcher with a particular interest in health workforce development.

Dr Steven Mark Brian Ariss is a Research Fellow at the School of Health and Related Research, University of Sheffield, UK.

Pam Enderby is a Professor Emeritus of Community Rehabilitation in the School of Health and Related Research University of Sheffield. She is a Speech and Language Therapist and has worked clinically and conducted research related to intermediate care.