The High Performing Surgical Team

A GUIDE TO BEST PRACTICE

Supports Good Surgical Practice

Domain 3: Communication, Partnership and Teamwork

RCS

ADVANCING SURGICAL STANDARDS

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INTRODUCTION

Most surgical work takes place in teams, whether in the operating theatre, with colleagues in audit meetings and mortality and morbidity meetings, in larger teams of allied health professionals such as multi-disciplinary teams (MDT), or in management team meetings. While technical innovation and improvements go a long way in ensuring successful surgery, non-technical skills such as effective team work and communication are essential for ensuring patient safety and for the provision of high quality surgical services.

This document is intended to serve as a practical guide for surgeons who work in teams and for those responsible for developing teams and improving team performance. It highlights both technical processes, such as the *WHO Surgical Safety Checklist*,[1] and the non-technical skills, such as communication and team reflection, which contribute significantly to the performance of the team.

This guide complements the College's guidance *Surgical Leadership – A Guide to Best Practice*[2] and can be used as a tool for implementing the principles of *Good Surgical Practice*[3] around team working and behaviour. It sets out the rationale for effective team working, the recommended attributes and behaviours expected of a high performing team and those features which characterise good team working. This document can also inform training, development and assessment of surgical teams. The focus is on achieving positive outcomes for patients and a culture that promotes openness and safety in surgery.

IMPORTANCE OF EFFECTIVE TEAMWORKING

According to *Good Surgical Practice*,[3] 'surgeons have a duty to promote a positive working environment and effective surgical team working that enhances the performance of their team and results in good outcomes for patient safety'.

All work in the NHS is now done in teams and team working is thus at the centre of safe, effective patient care. The patient's journey through the system from the moment they enter the hospital is influenced and supported by various teams. The patient's care requires surgeons to change roles between working as a leader of the team during surgery, and then as a member of the team at various points along the care pathway. Surgeons are also required to contribute to management teams, audit meetings and other team scenarios. Therefore it is important to understand the attributes of a high performing team and the behaviours that characterise good teamworking.

A number of recent developments have further highlighted the importance of effective team working:

- The 2013 Francis report following the Mid Staffordshire Public Inquiry[4] placed increased focus on medical professionalism and collegiality, as well as patient safety and the role of culture and behaviour in promoting safe care in healthcare teams and organisations.
- There is growing evidence about the direct links between medical errors and behaviour in the operating theatre (particularly errors around team working and communication). Evidence also suggests that effective teams are more innovative and their members have greater job satisfaction and less risk to their mental health.[5,6]
- The introduction of revalidation and enhanced appraisal have stressed the importance of good team working by including colleague feedback as a key source of supporting information for maintaining one's licence to practise.
- The contractual relationship between surgeons and their employers requires increasingly more corporate engagement and team working with both clinical and managerial colleagues.

CRITICAL ATTRIBUTES OF SURGICAL TEAMS

Good team work depends on the presence of a number of attributes that reflect the culture of the team, ie 'the way things are done in this team' and contribute to the team's performance. There is evidence to suggest that when teams exhibit infrequent team behaviours, patients are more likely to experience death or major complications.[7] There are several tools (eg the *WHO Surgical Safety Checklist*[1] or questionnaires) and techniques (eg team building; conflict management training) that can facilitate the development of team working but the first place to start is to review the critical attributes of a high performing team and make use of this information to develop a team and promote a positive team culture. The following attributes are critical to the development of a high performing team:

Membership

Teams come together for a specific task and the right membership is therefore important in achieving that task. Whether this is a theatre team whose objective is to perform a patient procedure; an MDT whose objective is to decide an appropriate care plan; or a management team whose objective is to improve efficiency, having the right team membership is the first step to achieving the objective. Teams should be constituted of the right number of people with the appropriate level of skill.

In high performing teams, members:

- understand their own and other members' roles and responsibilities
- encourage contributions of all members and ensure that the views of new and junior members are taken into account
- show respect for the role, expertise, competence and contributions of allied disciplines and healthcare providers.
- respect the leadership of the team
- have the shared goal of high quality care for the patient
- show a commitment to team work in the best interest of the patient
- recognise they are important to the outcome of the task
- feel confident to raise their voice or intervene.

Leadership

Effective teams have a leader who provides clear direction and to whom team members look to for guidance. There may be several leaders in a team (eg lead nurse, lead surgeon, manager, finance lead etc) although overall it should be clear who is leading the team at any one time. Alternatively there may be a designated team leader who delegates tasks to those with more expertise in a particular area.

The manner in which the team is led has a significant influence on the effectiveness of the team. Research has shown that clinical teams led by individuals who have a non-threatening style learn new routines and procedures more quickly and effectively.[8] For example, the team leader can downplay status and power differentials by commenting on their own fallibility or elevating the value and importance of others. This in turn results in a safer interpersonal climate, which encourages others to speak up and voice concerns or raise questions.

A high performing team therefore has:

- clearly defined leadership roles, particularly in critical situations
- a leadership style that minimises status and power differences
- a style appropriate to the particular situation
- leaders who continuously solicit input from team members and engage in team-based decision making
- leaders who are flexible enough to modify their approachand objectives as new information emerges or conditions change.

Communication

High performing teams are characterised by communication which is timely, clear, open and respectful. Communication between individual team members (eg through the use of the *WHO Surgical Safety Checklist*[1]) and between teams (eg at handover) is important. Team members should feel they can speak up, provide a view and know that they will be heard and listened to where appropriate. Good communication depends on relaying the content accurately and clearly but also on the style and skills of communication.

1. Content of communication

The content of communication should be focused on information sharing. Information is described by Michael West as 'data which alters the understanding of the team as a whole and/or of individual team members'.[9] In order for the whole team to understand why certain actions are being taken and therefore to calibrate their own actions accordingly, they must be kept up to speed with the most up to date information.

Information sharing should be timely and accurate. Those sharing information should check for verification of understanding and others should feel free to ask questions if they are not sure about the information they are receiving.

2. Communication skills

Communication skills important for effective teamworking include:

- listening attentively and allowing people to complete their thoughts.
- asking questions for clarification
- probing and asking for further detail
- checking with the speaker that you have understood them correctly
- challenging counterproductive behavior in colleagues constructively, objectively and proportionately

- being open to feedback from all team members and willing to reflect on feedback about performance and behavior and acknowledging any mistakes
- inviting opinions from those who have not voiced their view.

3. Communication at handover

Good communication is important not only between members of the same team but also between teams when transferring the care of a patient. According to *Good Surgical Practice*,[3] surgeons should ensure that there is a formal and explicit handover for the assessment, treatment and continuing care of patients for whom they are responsible to another named colleague following periods of duty or when they are unavailable for any reason.

Effective communication during handover requires that members of the oncoming team have full access to all necessary clinical information about the patient, and that the patient's notes are clear and sufficiently detailed and take into account the level of knowledge of the oncoming team members.

Coordination of tasks

Effective coordination of tasks relies upon the presence of confident leadership and on all team members knowing their own role. It is particularly important when team membership changes and new members join. The successful achievement of the team objective is dependent on coordination between team members so that work isn't duplicated and that everyone understands their role in the task. Patient care is dependent on good coordination pre- and post-operatively. Handover times are specific points when both communication and coordination are particularly relevant.

In MDTs and other meetings where expertise and power can threaten coordination it is important that individuals recognise how their own status and position can influence the success of the team. Coordination is dependent on everyone understanding their role and accountabilities and not asserting special privileges because of their status or expertise.

Effective coordination requires:

- all team members to be accountable for the achievement of the objective
- accountability for their own performance and for that of the team
- members to be aware of the mutual performance of the team
- members to be willing to provide support and backup
- effective continuity of care, including structured handovers through all phases of care
- ability of the team to remain flexible and adaptable to changing situations
- circulation of agendas, information and notes etc in advance of the meeting so that all are equally aware of the content and purpose of the meeting, and have the opportunity to prepare in advance.

Safe interpersonal climate

Team members are likely to feel committed and involved in the team if they feel interpersonally safe. Mutual trust and respect are important features here. In a safe interpersonal environment team members feel free to express their views, challenge one another and raise concerns without fear of ridicule, attack or recrimination. They also feel safe to discuss errors and mistakes. There is focus on team results and an absence of personal agendas, and the climate is non-threatening.

Differences of opinion and conflict are inevitable when individuals see things through their own lens and do not understand/recognise or tolerate the perspective of others. Conflict can be healthy and even necessary, as long as it is handled constructively. Healthy conflict can increase creativity and allow differences to be addressed rather than leaving them to fester. Where there is conflict and difference in the team the issues should be explored openly and constructively through:

- careful listening and respectful questioning
- an exploration of opposing views and seeking out of information
- open-minded consideration and understanding

- an acceptance for diversity of opinion
- concern for a high quality solution and outcome.

Review, reflection and learning

High performing teams take the time to review their performance and reflect on what they can do to improve. Guidelines around the use of the *WHO Surgical Safety Checklist*[1] provide a framework and process for team members to engage in review and discussion at the end of the operating list or at the end of the operating session.

In reviewing and reflecting on performance, it is useful to:

- seek and accept feedback about one's own performance as a team member
- review the team's performance and how well the team members worked together
- thank team members for their contribution to the outcome
- seek suggestions for how performance can be improved
- listen to ideas (even radical ones) for processes and procedures improvement.

A simple way of reviewing and reflecting on performance is to ask:

- what did we do well?
- what could we have done better?
- what should we stop doing?
- what should we continue doing?
- what should we start doing?

More in-depth learning is achieved through the regular morbidity and mortality (M&M) meetings, which are a standard feature of surgeons' life. The function of M&M meetings is both educational and one of quality assurance. They provide surgeons with the opportunity to discuss cases when the outcome was not as anticipated and to review errors, complications, adverse events and deaths in an open and reflective manner.

The Imperial College London, in collaboration with the Oregon Health and Science University, developed a standardised approach to M&M presentations aimed to maximise the learning outcomes of the meetings for all attendees.[10] According to this model, an M&M presentation should be comprised of:

Situation

Brief description of the case, including the admitting diagnosis, statement of operation and adverse outcome.

Background

Succinct description of the events and all clinical information pertinent to the adverse event.

Assessment and Analysis

Evaluation of what happened (error analysis) and why it happened (root case analysis) including human errors (eg error in diagnosis or in communication), systems errors (eg poor supervision, low staffing), and patient-related errors (eg patient disease).

Review of Literature

Present literature pertinent to the complication and identify the learning point for the case.

Recommendations

Propose actions to prevent future similar problems.

WHO SURGICAL SAFETY CHECKLIST

The *WHO Surgical Safety Checklist*[1] is a set of safety checks designed to safeguard and improve team performance at critical points in the patient's intraoperative pathway. *Good Surgical Practice*[3] includes the use of the WHO checklist and its adaptation through the *Five Steps to Safer Surgery*[11] as an essential part of teamworking in the operating theatre.

The checklist should not be used as a tick-box exercise and can be adapted to suit local clinical governance processes and different specialties. From February 2010 all NHS organisations in England and Wales were required to use it and to keep a copy of it in the clinical notes or electronic record. Additionally, specific checklists have been developed in non-surgical specialties (eg ophthalmology, radiology and maternity) to address particular risk factors.

Used properly the checklist is a quick way of ensuring coordination and communication between relevant team members, thereby facilitating positive surgical outcomes. The checklist sets the scene for surgery: it is a 'proactive information exchange'[12] enabling the whole team to focus on the patient, potential problems and challenges. It facilitates a discussion of 'the detailed components of care that, where implemented, can reduce significant incidents and improve communications to reduce the incidence of avoidable error and omission'.[12] It ensures that the team shares information about potential safety problems and concerns related to the patient and the process. When used as a part of the normal way of working, rather than on an exceptional basis, it helps to embed the recognition and reporting of safety issues into every day work.

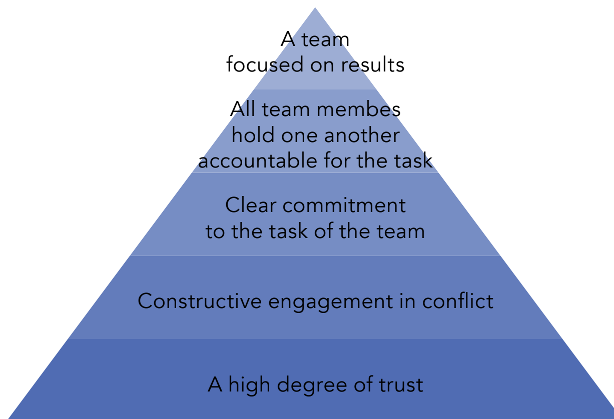
The *WHO Surgical Safety Checklist*[1] comprises of the following broad tasks:

- **Team briefing:** All members of the surgical team should attend the team briefing at the beginning of the list to ensure a shared understanding of the requirements of that list, identify skill levels, staffing and equipment requirements, and prepare for anticipated problems.
- **Sign in** before the administration of anaesthesia allows the team to ensure that the surgical site on the patient's body has been properly marked and the patient's known allergies have been checked.

- **Time out** before the first incision allows members of the wider theatre team to introduce themselves if they have not previously done so and encourages them to speak out if they identify any concerns at this stage.
- **Sign out** before the patient leaves the theatre guarantees that instruments, sponges and needles have been counted to ensure that none have been left behind in the patient's body.
- **Debriefing:** all members of the surgical team should participate in a discussion at the end of the operating list or at the end of the session, to consider good points of the operating process and teamwork, review any issues that occurred, answer concerns that the team may have, and identify areas for improvement.

HOW TO RECOGNISE A WELL-FUNCTIONING SURGICAL TEAM

In well-functioning teams you can expect to see the following characteristics in relation to the way the team works (based on Lencioni[13]). These are only likely to be obvious on a sustained basis if the team is well set up (ie the critical attributes of the team are present) and individual members behave appropriately (ie demonstrating positive behavioural markers).



A high degree of trust

In teams with a high degree of trust, team members:

- admit mistakes and weakness
- ask for help
- accept questions and input about their area of responsibility
- give one another the benefit of the doubt before arriving at a negative conclusion
- take risks in offering and accepting feedback
- appreciate and tap into one another's skills and experiences
- focus time and energy on important issues, not politics
- offer and accept apologies without hesitation
- look forward to meetings and other opportunities to work as a group.

Constructive engagement in conflict

In teams where there is a high degree of trust and constructive engagement in conflict, you can expect to:

- have lively, interesting meetings with a clear purpose
- extract and exploit ideas from all team members
- solve real problems quickly
- minimise politics and status differentials
- put critical topics on the table for discussion
- address the issue, not blame individuals.

Clear commitment to the task of the team

In teams where there is a high degree of trust and constructive engagement in conflict, you can expect commitment to the task of the team from all team members. Where there is clear commitment to the task of the team you can expect:

- clarity around direction and priorities
- alignment from the entire team around common objectives
- development of an ability of team members to learn from mistakes
- to take advantage of opportunities for innovation and service improvement
- the team to move forward and integrate new learning without hesitation
- changes of direction without hesitation or guilt.

All team members hold one another accountable for the task

In teams where there is a high degree of trust, constructive engagement in conflict and clear commitment to the objective, you can expect that all team members will hold one another to account for the successful achievement of the objective or task. When team members hold one another accountable for the achievement of the task you can expect that the team will:

- ensure that poor performers feel pressure to improve
- identify potential problems quickly by questioning one another's approaches without hesitation
- establish respect among team members who are held to the same high standards
- avoid excessive bureaucracy around performance management and corrective action. There is likely to be a team culture of open communication where feedback is requested, accepted and acted upon.

The team is focused on results

In teams where there is a high degree of trust, constructive engagement in conflict, clear commitment to the objective, and team members hold one another to account, you can expect that all team members will focus on results instead of their own status and ego. In high performing teams, which meet all the previous expectations, you can expect that the team will:

- retain achievement-orientated employees and there will not be a high turnover
- minimise individualistic and power-orientated behaviour
- enjoy success and suffer failure acutely
- benefit individuals who subjugate their own careers and individual goals
- avoid distractions.

DYSFUNCTIONAL TEAM WORKING: CAUSES AND SYMPTOMS

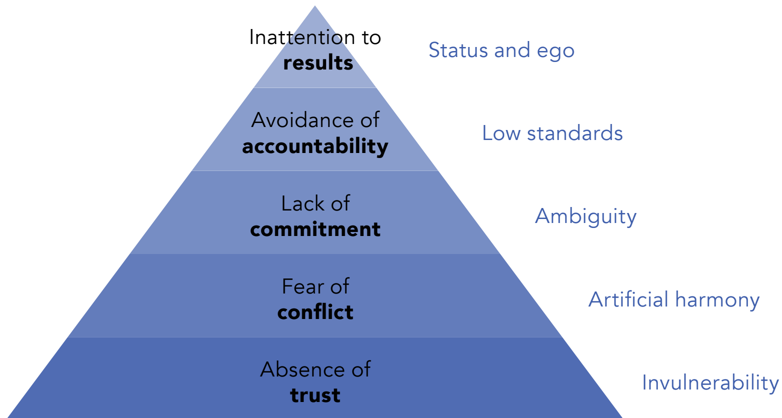
The context for team dysfunction

The pressures on the health service are intense and continuous. There is a relentless drive to reduce costs while raising standards; doctors are being asked to work harder and often longer, and there is less time to discuss, learn and reflect during regular working hours. Consultants are supported by junior staff but the move to consultant-delivered care, rather than consultant-led care means that doctors are now faced with not only managing the services but also delivering the care directly. Services are now under more scrutiny and regulation than ever. Patients are more knowledgeable and are often more demanding of consultants and the service in a context where there is less time and resources to meet all the demands.

Low staff morale and target-driven priorities make it difficult to maintain team members pace and motivation at a constantly high level. The Francis report[4] highlighted a number of attitudes as features of a negative culture and factors which contribute to team dysfunction. Those are, amongst others: bullying, disengagement from management, lack of candour, isolation, acceptance of poor behaviour, and denial.

Dysfunctional team working

In attempting to understand dysfunctional teams the work of Lencioni[13] illustrated below, provides a useful framework. The dysfunctions are cumulative and begin with the bottom level. They are not mutually exclusive and if left unaddressed precipitate the development of the dysfunction at the next level.



- At the first level a team with an **absence of trust** thinks it is invulnerable. Members don't trust one another enough to admit their own weaknesses – they will be reluctant, for example, to say 'I don't know' and individuals will not allow their vulnerability or concerns to show or come to the surface.
- At the second level, a team with a **fear of conflict** results in an artificial state of harmony. Individuals are afraid to disagree, challenge or raise their voice if it is in opposition to the leader or another member of the group. They will therefore be reluctant to challenge decisions for fear of conflict (ridicule, shaming, being shouted at etc). If there is fear of conflict, a junior nurse or doctor may be unlikely to raise their voice and point out mistakes, eg if a surgeon is about to operate on the wrong site.

West[9] talks about the need for *constructive controversy* in highly effective teams. He cites the following factors as being present and interfering in the capacity of a team to have constructive debates to resolve differences:

1. A competitive team climate.
2. Team goals are not primary.
3. Team members questioning one another's personal competence.

- At the third level, a team which shows a **lack of commitment** tends to revisit decisions again and again. They fail to come to a consensus and if they do, an individual will raise concerns before the decision is implemented; or will say for example, 'I had concerns but didn't want to raise them at the last meeting' (perhaps because he/she feared conflict). This behaviour is often a feature of management teams where the team finds it difficult to agree about a strategy; or where a strategy is agreed but concerns about it are raised after the meeting or in the next meeting, despite apparent initial agreement.
- At the fourth level, a team characterised by **avoidance of accountability** sets mediocre or low standards. People are reluctant to discuss and admit mistakes. They may ignore errors completely or attribute blame to others or to circumstances, eg a lack of resources, time or space, rather than openly acknowledge that they have made an error. People do not feel accountable in these teams and find ways to deflect blame.
- Finally, a team where there is **inattention to results** is easily distracted and encourages people to focus on their own status and ego. Individuals attend to what they did and they may narrow down their description of events to exactly what they did and how they did rather than see what they did or failed to do in the context of the team. They are concerned to preserve their own sense of capability, reputation and esteem rather than take responsibility for the performance of the whole team.

APPENDIX I

Behavioural markers that influence team performance

Positive behavioural markers	Negative behavioural markers
Listening and exploring others' opinions. Being curious as to why they have these views by • Asking questions for clarification • Probing for evidence and examples	Interrupting before the person has finished speaking; aggressive challenges and put downs
Actively seeking and considering advice and opinion through: • Asking for alternative explanations, thoughts • Encouraging views from everyone	Never asking for alternate ideas or opinions, making decisions without canvassing opinions
Supporting and encouraging team members to offer input, raise concerns, provide feedback; offer visible support for colleagues who face resistance	Belittling or humiliating others with sarcasm; only listening to those of a similar status and opinion
Question and challenge colleagues in a respectful manner who do not comply with rules and regulation no matter their status	Ignoring, denigrating, dismissing, ridiculing their views
Constructive conflict resolution through • Listening and exploring • Reflecting on others' arguments • Appreciating the points you agree with • Explaining why you disagree with others • Explaining your decisions	Being competitive and determined to prove you are right; aggressive argument which undermines/ignores the other person's point of view; assume you are always right because of your position or knowledge
Adapting and adjusting your roles and views when necessary; being prepared to give and take	Adopting the same approach in every situation; always asserting your status even when you are not the lead or the expert; never offering to do more than you are expected to
Offering positive feedback, appreciation, recognition for the contribution, effort of others	Never thanking, acknowledging, recognising another's contribution; regularly criticising without appreciating positive contributions

Seeking out and accepting feedback (positive and negative) about your own contribution and performance	Ignoring offers of feedback, responding aggressively/emotionally without due consideration of the feedback
Review and reflect on your own performance and contribution and that of the team's performance	Failing to reflect on your own performance and that of the team; not taking time to seek suggestions for personal and team improvement

APPENDIX II

A. Checklist for the high performing team member

		YES	NO
1.	I am clear what we are trying to achieve in this team	☐	☐
2.	I am clear about my role and accountabilities in this team	☐	☐
3.	I know what others' roles and accountabilities are in this team	☐	☐
4.	I am confident to speak up if I have a concern	☐	☐
5.	I respect my colleagues' skills and contributions	☐	☐
6.	I listen carefully when others are speaking	☐	☐
7.	I ask questions for clarification if I don't understand	☐	☐
8.	I am confident to say No or I don't know if I am asked to do something I am not capable of doing	☐	☐
9.	I take responsibility for my own actions	☐	☐
10.	I share responsibility for the actions of the team	☐	☐
11.	I admit when I have made a mistake	☐	☐
12.	I encourage and support my colleagues to raise their concerns	☐	☐
13.	I offer help and support when it is needed	☐	☐
14.	I reflect on my own performance and what I could have done better	☐	☐
15.	I contribute to team discussions about how to improve the performance of this team	☐	☐

B. Checklist for the high performing team

		YES	NO
1.	We are focused on patient safety and quality outcomes	☐	☐
2.	We know we can rely on one another	☐	☐
3.	We all understand our roles and accountabilities	☐	☐
4.	We recognise and respect individual differences	☐	☐
5.	We feel confident raising concerns – we can speak up	☐	☐
6.	We feel comfortable challenging one another if we are concerned about a decision/action	☐	☐
7.	We acknowledge and manage conflict constructively	☐	☐
8.	People do not assert their status unnecessarily	☐	☐
9.	Communication is timely and clear	☐	☐
10.	We are able to influence and contribute to decisions	☐	☐
11.	We are keen to learn	☐	☐
12.	We feel that our ideas and work is acknowledged and appreciated	☐	☐
13.	We can safely discuss errors and mistakes	☐	☐
14.	We support the introduction of new ideas and improved ways of working	☐	☐
15.	We are encouraged to offer ideas and to review our own and the team's performance	☐	☐
16.	We respect the leadership of this team	☐	☐

REFERENCES

1. WHO surgical safety checklist and implementation manual. World Health Organization. http://www.who.int/patientsafety/safesurgery/ss_checklist/en/ (cited 15 October 2014).
2. The Royal College of Surgeons of England. *Surgical Leadership – a guide to good practice*. RCSE; 2014.
3. The Royal College of Surgeons of England. *Good Surgical Practice*. London: RCSE; 2014.
4. The Mid Staffordshire NHS Foundation Trust Public Inquiry. The Mid Staffordshire NHS Foundation Trust Public Inquiry 2010. http://www.midstaffspublicinquiry.com/ (cited 15 October 2014).
5. Buttigieg SC, West M, Dawson JF. Well-structured teams and the buffering of hospital employees from stress. *Health Serv Manag Res* 2011; **24:** 203–212.
6. West M, Borrill CS, Dawson J, Brodbeck F. Leadership Clarity and Team Innovation in Health Care. *Leadership Quarterly* 2003; **14:** 393–410.
7. Mazzocco K, Petitt DB, Fong KT *et al*. Surgical team behaviours and patient outcomes, The Am J Surg 2009; 197: 678–685.
8. Edmondson AC. Speaking Up in the Operating Room: How Team Leaders Promote Learning in Interdisciplinary Action Teams. *J Manag Stud* 2003; **40:** 1,419–1,452.
9. West M. *Effective Teamwork*. London Wiley-Blackwell; 2010.
10. Morbidity and Mortality Conference Manual v.1.1. Imperial College London. http://www1.imperial.ac.uk/resources/F81B6B10-0BB4-4A3E-AB6F-4D62EE642E4F/mmmanualv1.1dec2012rev.pdf (cited 15 October 2014).
11. Five steps to safer surgery. Patient Safety First. http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Perioperativecare/5stepsvideo/ (cited 15 October 2014).
12. The How to Guide for Reducing Harm in Perioperative Care. Patient Safety First. http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/Perioperative%201.1_17Sept08.pdf (cited 15 October 2014).
13. Lencioni PM. *The Five Dysfunctions of a Team*. San Francisco: Jossey-Bass; 2002.

FURTHER READING

Briffa N. Putting a stop to preventable deaths, *Health Serv J* 2013; **123:** 21–23.

Buttigieg SC, West M, Dawson JF. Well-structured teams and the buffering of hospital employees from stress. *Health Serv Manag Res* 2011; **24:** 203–212.

Edmondson AC. Speaking Up in the Operating Room: How Team Leaders Promote Learning in Interdisciplinary Action Teams. *J Manag Stud* 2003; **40:** 1,419–1,452.

Imperial College London. Morbidity and Mortality Conference Manual v.1.1. http://www1.imperial.ac.uk/resources/F81B6B10-0BB4-4A3E-AB6F-4D62EE642E4F/mmmanualv1.1dec2012rev.pdf (cited 15 October 2014).

Katzenbach JR, Smith DK. *The Wisdom of Teams: Creating the High-Performance Organization*. New York: Harper-Perennial; 1999.

Lencioni PM. *The Five Dysfunctions of a Team*. San Francisco: Jossey-Bass; 2002.

Mazzocco K, Petitt DB, Fong KT *et al*. Surgical team behaviours and patient outcomes, The Am J Surg 2009; 197: 678–685.

The Mid Staffordshire NHS Foundation Trust Public Inquiry 2010. The Mid Staffordshire NHS Foundation Trust Public Inquiry. http://www.midstaffspublicinquiry.com/ (cited 15 October 2014).

Patient Safety First. The How to Guide for Reducing Harm in Perioperative Care. http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/How-to-guides-2008-09-19/Perioperative%20 1.1_17Sept08.pdf (cited 15 October 2014).

The Royal College of Surgeons of England. *Surgical Leadership – a guide to good practice*. RCSE; 2014.

The Royal College of Surgeons of England. *Good Surgical Practice*. London: RCSE; 2014.

Sexton JB, Thomas EJ, Helmreich RL. Error Stress and Teamwork in Medicine and Aviation: cross sectional surveys. *BMJ* 2000; **320:** 745–749

World Health Organization. WHO surgical safety checklist and implementation manual. http://www.who.int/patientsafety/safesurgery/ss_checklist/en/ (cited 15 October 2014).

West M. *Effective Teamwork*. London Wiley-Blackwell; 2010.

West M, Borrill CS, Dawson J, Brodbeck F. Leadership Clarity and Team Innovation in Health Care. *Leadership Quarterly* 2003; **14:** 393–410.

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Good Surgical Practice sets out standards for all surgeons and their practice. It has been developed in consultation with members and fellows, patients, surgical royal colleges and surgical specialty associations and reflects the profession's expectation of all competent surgeons.

www.rcseng.ac.uk/surgeons/surgical-standards/professionalism-surgery/gsp