The impact of leadership factors in implementing change in complex health and social care environments: NHS Plan clinical priority for mental health crises resolution teams.

EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

In summarising the findings of this national, longitudinal study of the relationship between quality of leadership in Mental Health Crisis Resolution Teams (CRTs) and both staff attitudes and well-being, and organisational performance, we would like to address three principal questions:

- What did we set out to achieve?
- What did we find?
- What are the implications?

What did we set out to achieve?

1. The development of CRTs over the past decade, and the policy initiatives to mainstream these crises services across England, presented an ideal backdrop against which to examine policy implementation and the impact of leadership on the functioning and performance of these teams.

   Consistent with the Department of Health Mental Health Policy Implication Guidelines (MHPIG), the teams were selected with reference to the Durham Mapping database, such that they: - were multi-professional in their composition; operated 24/7, 365 days of the year; and delivered services in the patient's home or community. The additional inclusion criterion of being in operation for at least 6 months was imposed.

2. The purpose of the investigation was to undertake longitudinal research to examine the relationship between quality of leadership and both staff attitudes to work and their well-being at work, and organisation performance, allowing for the effect of a wide range of contextual factors.

3. This was achieved through collection of a combination of quantitative and qualitative data, including 8 detailed Case Studies.

4. The principal hypothesis was: that the quality of leadership exhibited by CRTs is directly related to team effectiveness.

   Team effectiveness, which was defined in two ways: (1) staff attitudes to work and sense of well-being at work; (2) organisational performance, was tested through a series of subordinate hypotheses.

5. Complete data were available for a total of 46 mental health crisis resolution teams (CRTs) from different parts of England.

Review of the literature

6. In order to ensure that an appropriate model of leadership was adopted, an extensive review was undertaken of the relevant literature.

Our understanding of the history of the formal academic research into the nature of leadership is that it can be seen to have developed through 5 main stages: the 'trait' or 'Great Man' approach; the 'behavioural' approach, out of which the concept of managerial and later leadership competencies emerged; the 'situation' or 'contingency' approach; the 'new paradigm' approach, with its focus on 'distant' transformational, often 'heroic' leadership; and finally, the emergence of 'nearby' transformational or 'engaging; leadership, and the associated concept of 'distributed' leadership.

7. It was suggested that it is valuable to distinguish two aspects of leadership – 'what' a leader does, and 'how' they do it.

The first of these, as exemplified by the NHS 'Leadership Qualities Framework', the police 'Integrated Competency Framework', and the fire and rescue service 'Personal Qualities and Attributes', can be seen to reflect leadership competency, which may be defined as follows:

> A competent leader is someone who enables the development of an organisation in a way that is *goal directed*, and geared to developing *processes and systems*. This enables staff at all levels to *plan effectively and efficiently*, in order to *achieve agreed goals*.
>
> High levels of competency can lead to a *degree of consistency* within an organisation or department, and thereby enable staff to make *day-to-day decisions* and *short-term predictions*, with a measure of *confidence*.
>
> Leadership competencies, which are often largely closed-ended in nature, are necessary in order that staff can undertake both *strategic and day-to-day planning*, and in this way help to turn the *vision* of an organisation, department or team *into a reality*.

The second of these may be defined in the following way:

> A transformational or *engaging leader* is someone who encourages and enables the development of an organisation that is *characterised by a culture* based on *integrity, openness and transparency*, and a *genuine valuing of others*.
>
> This shows itself in concern for the development and *well-being of others*, in the ability to unite different groups of stakeholders in articulating a *joint vision*, and in delegation of a kind that *enables* and develops potential, coupled with the *encouragement of questioning* and of *thinking which is critical* as well as *strategic*.
>
> Engaging leadership is essentially open-ended in nature, enabling organisations not only to *cope with change*, but also to

be *proactive in shaping their future*. At all times, 'nearby' transformational behaviour is guided by *ethical principles*.

Recent research in the US, UK and more widely, has pointed to the significant impact of an engaging style of leadership on organisational performance among a wide range of medium to large-size companies. Research conducted in the NHS and local government in the UK, (and replicated in FTSE 100 companies) that was inclusive of gender, ethnicity, and level, has provided a robust metric, of proven validity, for assessing this kind of leadership behaviour.

8. Another important conclusion was that transformational or engaging leadership behaviours cannot be assessed as if they were some kind of 'add on' to an existing 'competency framework'.

The reasons for this stem in part from the criticism that competency frameworks provide an overly 'reductionist', fragmented account of leadership behaviour. As two American writers recently put it,

> "What matters is not a person's sum score on a set of competencies, but how well [or as we would put it, *in what way*] a person uses what talents he or she has to get the job done." (Hollenbeck *et al*. 2006).

Two similes are relevant here. Alimo-Metcalfe and Alban-Metcalfe (2005) suggested that anyone could paint a Monet if one could deconstruct a beautiful painting into a 'painting by numbers' exercise.

Bolden and Gosling (2006) offered a musical simile:

> "a competency framework could be considered like sheet music, a diagrammatic representation of the melody. It is only in the arrangement, playing and performance, however, that the piece truly comes to life."

9. To paraphrase an expression used by Neil Kinnock,[1] when properly constructed, leadership competencies can be likened to Brighton Pier, very fine in their own way, but not a good way of getting to France. The conclusion drawn here can be summarised as follows: neither competent nor engaging leadership should be seen as superior to the other; rather, they should be seen as complementary, with the suggestion that leaders should lead competently, in a transformational or engaging way.

10. Increasingly, organisations concerned with the need to build internal leadership capacity, are moving towards the notion that it is not so much about a what leader **does** but rather **a process** that engenders

[1] When describing the Special Education Act (1981).

leadership behaviours in others'. Indeed, this purpose is a central feature of the nature of 'engaging leadership'.

11. A complementary way of interpreting the leadership research is to suggest that the development of leadership competencies results in an increase in 'human capital', which, through the enactment of engaging behaviours, can be turned into 'social capital'. This has implications for leadership development.

Data collection:

12. The 'Leadership Climate & Change Inventory (LCCI)™ was used to assess the quality of leadership. The LCCI comprises two sets of items, those that assess the competency or 'leadership capability' of a team, and those that assess transformational or engaging leadership behaviours. The LCCI also assesses twelve facets of attitudes to work and well-being at work.

13. Following a visits to each of the 100 CRTs that originally agreed to participate in the study, the LCCI was administered to all staff, under conditions that ensured complete anonymity.

14. In order to ensure the validity of the LCCI in the present context, the responses from 731 staff were factor analysed. The emergent structures suggested the existence of three scales. Two of these, which were labelled 'Engaging with Others' and 'Visionary Leadership', assessed different aspects of transformation or engaging behaviour; the other was labelled 'Leadership Capability'.

15. Contextual data were collected in relation to the following factors: -the proportion of service-users diagnosed as showing symptoms of psychosis; the Mental Illness Needs Index (MINI) for the locality; the availability of alternatives to in-patient provision; the age of the team; the number of staff who deal with a given service user; the extent to which the team had gate-keeping control over in-patient admissions; the amount of dedicated clinical support available to the team; the extent to which the team was multi-disciplinary; and the extent to which the team offered 24/7, 365 day cover.

    Some of this information was collected from the team lead, either during the initial visit, when the nature and purpose of the study was explained, or subsequently from the team. The other information was obtained from official statistics.

16. Organisational performance was assessed in four ways: 'ratio' – the number of assessments made by a team to the number of referrals for inpatient care as an average over a twelve month period; 'change' – defined as any differences in the 'ratio' over a 12-month period; 'productivity' – calculated by dividing the 'ratio' scores by the number of

members of the team; and ‘change in productivity’ – defined as an differences in the ‘ratio’ over a 12-month period.

It should be pointed out that whilst defining organisational performance in this way is open to criticism, such a definition is wholly in line with the criteria consistently adopted by the Department of Health.

17. A questionnaire-based, semi-structured interview was conducted with each of the team leads, which was designed to assess their approach to change management and identify which, if any, models of change management they used.

18. Extensive Case Study data were collected on the basis of detailed, one-to-one discussions with the members of eight teams, including the team lead, and with external agents who worked in association with the teams.

Of the teams selected, five were categorised as ‘high performing’, in terms of having a low assessments/referrals ratio, and three as ‘low performing’.

What did we find?

Relationship between leadership and staff attitudes and well-being:

19. Leadership quality, as measured by each of the 3 scales, was significantly positively correlated with each of the 12 facets of staff attitudes to work and their well-being at work. In other words, the leadership behaviours categorised as ‘Engaging with Others’, ‘Visionary Leadership, and ‘Leadership Capability’, had a positive effect on staff.

20. Further analysis of these relationships revealed strong predictive links between ‘Engaging with Others’ and each of the 12 facets, and between ‘Visionary Leadership’ and 6 of the facets, and ‘Leadership Capability’ and 4 of the facets. This suggests that leadership behaviours that involve ‘engagement’ have much the greatest impact on staff’s attitudes to work and their well-being at work.

Relationship between leadership and organisational performance:

21. At the level of whole teams, there was some evidence to suggest that organisational performance, defined in terms of ‘ratio’ scores (ratio of assessments to referrals), but not when defined in terms of ‘change’ scores, was positively associated with ‘Engaging with Others’.

No such relationships were found involving either ‘Visionary Leadership’, or ‘Leadership Capability’.

22. At the level of individual team members, ‘productivity’ (‘ratio’ in relation to number of staff), but *not* ‘ratio’, ‘change’, or ‘change in productivity, was significantly related to ‘Engaging with Others’, when the effect of the nine contextual factors had been taken into account.

No such relationships were found involving either ‘Visionary Leadership’, or ‘Leadership Capability’.

Relationship between contextual factors and organisational performance:

23. Again, when the data were analysed at the level of individual team members, it was evident that certain of the contextual factors assessed had a significant effect on organisational performance.

‘Productivity’ was affected positively by the staff/case ratio, the number of different staff involved in working with a given service user, whether the team performed a gate-keeping role, and whether alternatives to inpatient care were available. Conversely, ‘productivity’ was related negatively to the age of the team, the amount of medical cover available, and the proportion of service users presenting symptoms of psychosis.

Relationship between leadership, contextual factors and organisational performance:

24. The relationship between leadership, the contextual factors that were studied, and organisational performance, was examined in two ways, hierarchical multiple regression analysis and structural equation modelling. The first of these is designed to determine the *relative* strengths of the impact that each contextual or leadership variable has on the outcome (organisational performance). The second, structural equation modelling, specified alternative ways in which the different variables interact both with one another, and with the outcome.

25. Both sets of analysis suggest: (1) that ‘Engaging with Others’ (but not either ‘Visionary Leadership’ or ‘Leadership Capability’) has a significant impact on the ‘productivity’ of teams; (2) seven of the nine contextual variables have a significant impact on ‘productivity’, some positive, others negative; and (3) that the impact of some of the contextual factors is greater than the impact of the leadership behaviours identified as ‘Engaging with Others’.

Put simply, this suggests that, while certain kinds of leadership behaviour, specifically that characterised as ‘engagement’ does have a significant effect on organisational performance, contextual factors too can be demonstrated to have a significant impact. Also, the impact of some of the contextual factors studied was positive, others negative.

However, when the effects of contextual variables are controlled for, ‘engaging leadership’ does predict/explain **additional unique variance**

in performance effectiveness of the team That is, (irrespective of the effect of contextual variables), engaging leadership had a significant impact **over and above** that predicted by contextual variables

26. These observations are borne out by the Case Study data to the extent that both leadership behaviour and contextual factors affect organisational performance. However, what the Case Study data also point to are: (1) that contextual factors other than those that were the subject of quantitative analysis can have an impact on organisational performance; and (2) that in some situations, such contextual factors can have an influence that supervenes quality of leadership in a team.

Change management:

27. An hypothesised link between quality of leadership and a transformational approach to change management proved impossible to test. This was largely owing to practically all team leads describing the approach they had adopted as transformational in nature.

28. What this part of the study did reveal, however, was that teams leads appeared to used models of change that they themselves did not overtly recognise as having any particular theoretical base.

Case Studies:

29. Analysis of the Case Study data resulted in the emergence of a number of themes. These included: relationships within the team and with external agencies, including the impact of contextual factors; attitudes to change; the experience and confidence of team members; and team structure and leadership.

30. The extent to which teams were successful in achieving their targets, depended to a very great extent on the nature and quality of the relationships they had with a range of external stakeholders with whom they have to operate. Where mutually-agreed protocols had been drawn up, this tended to be beneficial to the smooth-running and effectiveness of the team.

    Linked to this, there was a perceived need both for better definition of the boundaries between the responsibilities of different agencies (CRTs, CMHTs, GPs, A&E, &c.) working with different groups of service users, and for adherence to boundaries and protocols. Related to this, contextual factors (including those referred to here), over which the team has no control, were seen to have a supervening influence on the functioning and performance of teams.

31. Many teams expressed the need to have a greater sense of stability, though it was also evident that change can be a stimulus to greater achievement. Good leadership was seen to be effective in overcoming resistance to change.

32. Teams were conspicuous in making effective use of human and material resources, which were often limited.

33. Where medical models of provision were seen to dominate, they could have a deleterious effect on performance.

34. With regard to team structure, teams were seen to work best where there were 'flat' hierarchies, and 'whole team' approaches were adopted in dealing with issues. Related to this, having a senior management team that tended to be remote from the rest of the team, particularly in the case of larger teams, had a debilitating effect on the functioning of the team.

    Furthermore, team leads were seen as more credible when they showed that they too were able to work directly with service users;

35. Two aspects of staff intrapersonal attitudes, and the way they should carry out their duties emerged. One was that the extent to which different team members were willing to take risks was related to their personal confidence, which was, in turn, related to the nature of, and the amount of, experience that they had, and the support available within the team.

    The other was teams' attitudes to inpatient care. Specifically, whether or not they regarded admission as an absolute last resort appeared to be relevant to admission rates.

36. 'Good leadership', including having a vision, networking, and managing in an efficient and supportive way, was seen as fundamental to the effective functioning of teams.

37. Lastly, it was recognised that 'good leadership' on it own does not guarantee low admissions rates.

Overview of findings:

38. Overall, the results indicate that, while the three aspects of leadership studied were positively associated with staff attitudes and well-being, to a greater or lesser extent, only 'engaging' leadership behaviours were a significant **predictor** of organisational performance.

39. Furthermore, both the quantitative and qualitative data point to the significant effect of contextual factors on organisational performance.

What are the implications?

Implications for health practitioners:

40. The importance of good quality leadership in any health service cannot be emphasised enough. One of the key findings from the current study demonstrated this by revealing a significant relationship between good quality leadership and the effective functioning of a CRT.

41. Good leadership, more specifically engaging with others, was also important in predicting positive staff attitudes towards work and well-being at work. The significance of this for practitioners includes the importance of feeling self-confident and having the discretion to take decisions within a well-defined structure.

42. Equally important, is the creation of a work environment in which staff feel empowered, are supported by their manager, have opportunities for development, and are highly motivated and satisfied with their job.

43. A further implication for practitioners derives from the concept of shared or distributed leadership, and the acknowledgement that all team members play some part in the leadership culture of the team and its potential to operate successfully.

44. The findings, therefore, emphasise the importance of leadership as a shared or 'distributed' process.

Implications for managers:

45. The relative prominence of the Team lead appeared pivotal to a well functioning team, and demonstrates the importance of an engaging approach to leadership in this particular person. Being an experienced practitioner, as well as an effective manager, emerged as crucial requirements for success in the role of Team lead. Some also had postgraduate training.

46. The impact of good leadership as identified by team members revealed how a supportive, collaborative, visionary and a pragmatic approach to managing a CRT was highly effective in terms of maintaining good staff morale, developing a sense of purpose, having clarity of role, and creating good internal and external working relationships.

Policy implications and implications for new ways of working:

Leadership development

47. Change is an inherent feature of health care services, and good leadership is essential for ensuring that it is well managed. CSIP/NIMHE (2007) recognises the need for effective leadership to enable the 'New Ways of Working' in mental health become a reality.

48. Policy makers need (1) to recognise that managers and clinicians/professionals need *practical* guidance in how to approach managing change, and (2) to focus on the kind of leadership

development that goes beyond developing human capital, and addresses the issue of how best to also develop social capital, such that leadership becomes **embedded** in the culture of the team..

49. Iles and Preece (2006) pointed to fundamental differences between 'leader development' and 'leadership development' when they noted that,

> "Leader development refers to developing individual-level intrapersonal competencies and human capital (cognitive, emotional, and self-awareness skills for example), while leadership development refers to the development of collective leadership processes and social capital in the organization and beyond, involving relationships, networking, trust, and commitments, as well as an appreciation of the social and political context and its implications for leadership styles and actions."

50. If there is one message that comes across strongly, both from the review of the literature, and the empirical findings, it is that an engaging style of leadership is crucial to achieving success. The implications of this include questioning whether leadership development programmes that rely exclusively on developing 'leadership competency' can be regarded as fully 'fit-for-purpose'.

Leadership competencies can be effective in guiding leader development, and thereby increasing human capital, but an engaging style of leadership is what enables the release of human capital, and the creation of social capital.

Policy implementation and the introduction of new services

51. Service development policies should not be too prescriptive, as with the case of the MHPIG (1999); prescriptive policies ignore the local context and, as such, enforce teams to conform to a model that may not best fit their requirements. As such, policies should describe the reasons and desired outcomes of change rather than providing very detailed instructions on how the change should be achieved.

52. Human resource considerations: when introducing a new service, policy makers should consider the best means by which to create positive attitudes amongst staff, generating a sense of purpose, ownership and commitment to work.

53. HR professionals play a key role in building leadership capacity, by being actively involved in advising and scrutinising current selection, promotion, leadership development, and appraisal processes adopted by organisations, to ensure that they not only include competencies, but also most importantly, advocate the adoption of 'engaging transformational' approaches to **how** the competencies are enacted.

They should also be informed so that they can influence and 'educate' their colleagues as to why this is so important to the business of the quality of delivering healthcare.

54. A 'whole systems' approach to service provision was found to be a key element of successful inter-agency working; such an approach should be promoted as it is evident that good relationships between different agencies are crucial to improving crisis care.

55. Policy makers should reconsider the outcomes or performance targets expected of mental health services, such as admissions to hospitals, focusing instead on staff and service user satisfaction and other indicators of good quality mental health care.

Technical considerations:

56. **The fact that this study was longitudinal in design, is of critical importance, since this has enables conclusions to be drawn not only about 'associations' between a range of variables, but also about the nature of causal relationships between these variables over time.** As far as we are aware, this is the first investigation of its kind that has demonstrated the impact of the precise nature and quality of leadership on both: staff attitudes and well-being, and on organisational performance, when the effect of a wide range of contextual factors has been taken into account.

57. **The findings from this study add significant weight to the increasing disquiet being expressed in a number of recent publications to the preoccupation with describing leadership purely in terms of 'competencies'.**

58. Technically, this research takes the model of 'engaging' transformational leadership on which the LCCI was developed, to the forefront of understanding of what exactly an engaging style of distributed leadership looks like in daily interactions in teams.

Disclaimer

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Addendum

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