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Leadership and Better Patient Care: Managing in the NHS

Executive Summary

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Executive Summary

The NHS National Leadership Council Website[1] (NLC) following the NHS Next Stage Review: High Quality Care for All (Darzi, 2008) suggested the importance of effective leadership in the system emphasising the need for greater involvement of clinicians in leadership. Consequently the Clinical Leadership Competency Framework (CLCF) has been developed building on the Medical Leadership Competency Framework (MLCF) to incorporate leadership competencies into education and training for all clinical professions. This is a major step towards establishing and developing high-level leadership across the health service.

The NHS Institute for Innovation and Improvement (2005) *NHS Leadership Qualities Framework*[2] emphasised the *situational* nature of leadership and indicated the circumstances under which different leadership qualities will take precedence.

Formal studies of leadership date back (at least) to the beginning of the 20th century to seek the characteristics that make certain individuals influence others' behaviour (Alimo-Metcalfe, Alban-Metcalfe et al. (2007). Questions remain though about the significance of context for understanding how certain characteristics might be more or less relevant or effective in particular organisations (Fairhurst, 2009; Liden & Antonakis, 2009; Uhl-Bien, 2006). One important set of findings suggest that leadership does have an effect on organisational performance – for good and for ill (Currie, Lockett, & Suhomlinova, 2009; Schilling, 2009). Further, the context, culture, climate and/or structure of an organisation all have an impact on the performance of the people who lead in it (Carroll, Levy, & Richmond, 2008; Goodwin, 2000; Michie & West, 2004).

The NHS itself is complex and comprises different organisations including Primary Care Trusts, different types of Hospital Trusts, Foundation Trusts, teaching hospitals and other specialist institutions, all with their unique

[1] http://www.nhsleadership.org.uk/workstreams-clinical-theleadershipframework.asp

[2] http://www.nhsleadershipqualities.nhs.uk/

characters based upon their developmental histories, the histories of the communities they serve, and most crucially for this study, the people who work in them.

Our study aimed overall to seek out the meanings and perceptions of relationships between 'leadership' and 'patient care' and how leadership is transmitted across organisations to impact upon service delivery.

Two models of leadership are examined in this study:

First is inspirational and transformational (or engaging) leadership (Alimo-Metcalfe, Alban-Metcalfe et al., 2007).

Second is *distributed leadership* (Elmore, 2004; Gronn, 2002). Unlike traditional conceptions of heroic leadership, distributed leadership is the *sharing* of leadership between several individuals, who jointly generate commitment, cohesion and wisdom (Grint, 2000; Grint, 2005).

Furthermore the model of the post-industrial/postmodern and or networked organisation was explored taking a systemic approach in order to review the transmission of leadership and the impact of the organisational structure on service delivery (Campbell, Coldicott, & Kinsella, 1994; Collier & Esteban, 2000; Simpson & French, 2005).

Aims

The research questions in this study centre on identifying:

(a) processes by which leadership is transmitted through organisations to effect the delivery of health services, and

(b) how features of the organisation, the leaders and the service influence these processes.

Methods

Using both qualitative and quantitative methods, we focused upon three NHS Trusts, including one Foundation Trust, specifically to explore whether any variations in the qualities of leadership, organisation and patient care could be distinguished. Within each Trust we chose two distinct 'units' to study.

Focus groups, in-depth story-telling interviews, ethnographic observations and 'shadowing' methods, as well as an adaptation of a pre-existing measure of organisational climate (Stringer, 2002) were used.

The qualitative data were analysed using a variety of methods:

a. Thematic analysis (TA)

b. Critical Discourse Analysis (CDA)

c. Narrative analysis

The quantitative data were analysed using a mixture of descriptive and inferential statistical tests using SPSS v. 12.

Results

Leadership is a complex concept which is no surprise given the sheer amount of research and theoretical endeavour, for at least over the last sixty years, that has focused on encapsulating its 'essence'.

Nonetheless, the various stakeholders had views, some of which coincided with contemporary NHS discourses and some apparently directly at odds with what the NHS is trying to achieve – that is, to support both distributed and transformational leadership.

While vision is important, little can be achieved if the leader fails to take the followers with them. The culture of an organisation in which successful transformational leadership occurs, has to be emotionally and socially intelligent; leadership has to be distributed so that professionals at all levels are enabled to lead in the context of their specific expertise. The organisation that encourages the best people within it will also attract and retain the best people who go on to deliver the best service to patients.

Measuring organisational climate

'Satisfaction with leadership' was highly accounted for by manager 'support', manager 'commitment' and organisational 'support'. This concurs with the suggestion that managers/leaders were most effective if they engaged with followers and that organisations that supported distributed leadership and emotional engagement were more likely to support effective leadership.

Leadership, authority and the system

The interconnections between power, authority, the system and emotion play a complex part in understanding what leadership means and how it is transmitted in each organisational context.

Despite the increased numbers of women who have reached senior leadership positions in the NHS, there were nonetheless some important differences between women and men's leadership which need further exploration (Gill et al., 2008).

Leadership and Patient Care

Leadership and patient care are linked at a number of levels from Department of Health and NHS policy impacting upon the population in

general, to Trust management which impacts upon the local community and practices in clinical teams that in turn impact upon the way face-to-face care is delivered. Examples are provided in Chapters Nine and Ten.

Recommendations

- Leaders at every level of the NHS need to be fully *engaged* with their colleagues (who might be co-leaders and/or followers) in order to deliver effective and consistent patient care. This means that the leader should be aware of whether the colleagues/followers are being supported to play to their strengths and whether they are being both recognised and supported in the roles they are playing and the work they are doing. This will increase morale and establish a culture of pride in delivering good quality patient care.
- *Emotional and social intelligence and the ability to work reflexively* are a core component of effective leadership practices in the NHS as these qualities underlie effective service delivery.
- It is important for leaders at all levels to acknowledge *the emotional context of their relationship with colleagues* and particularly those with whom they need to engage as followers or conjoint leaders in service delivery practices.
- *Distributed leadership* should be supported further to enhance service delivery across the NHS as it is transformational in cases where concerted or conjoint action occurs in teams engaged in both management and direct delivery of patient care.
- These recommendations are essential for those at every level who are delivering *change* whether on time-limited, small-scale projects or larger-scale policy-driven ones.
- Leaders and followers need to understand and pay attention to *the system* in which they work and particularly to be aware of the *primary task* of their organisational unit or role (e.g. direct patient care, developing innovative practices) and that of the wider system, and the impact of changes upon the *boundaries* of their own organisation (e.g. when mergers occur).
- To increase socially and emotionally intelligent distributed leadership across the NHS, there is a need for ideas on how to implement and encourage effective leadership to be driven up the political and senior management agendas as well as across the organisations.

- Gender issues have still not been fully resolved despite increased numbers of women in senior roles. It is important to realise that more work needs to be done to ensure *best practices for leading at all levels* making sure that equal opportunities and greater understanding of gender similarities and differences are transparent.
- This all suggests that those involved in leadership training and manager selection need to take *emotional and social intelligence seriously*. This includes ensuring appropriate support for all leadership positions to enable role holders to operate on a 'people-centred' level.
- 'Emotion' is a core component of all organisational practices in the NHS whether it be about implementing and resisting change, concerns about (lack of) supervision and support or about patient care. It is important for this to be acknowledged and appropriate training and on-going support offered particularly (but certainly not only) for those involved with face-to-face patient care.
- It is not possible to change 'personality' through training. However, leadership does not reside in an individual *per se* so that it is possible to improve leadership effectiveness by paying attention to qualities required for leader/follower engagement and social and emotional intelligence as identified above. This will impact in a transformational way upon the culture and climate of the organisation.
- The research methods employed in this study have shed light on the *details* of leadership and patient care practices frequently obscured by more traditional methods of data collection. The benefits of the mixture of methods we employed have been discussed in Chapter Two and reviewed above in this chapter. Taking some of these methods forward we recommend that future research might consider:
    - A more intensive 'drilled-down' study of one particular Trust over a period of six months. This would involve a similar mixture of methods but would also include analysis of internal and external policy documents with an 'audit' of how they have been/are implemented (and resisted). This would provide information about both the *system* and where its strengths and weak points were located as well as data on the ways in which *power and authority were distributed* and their links to service delivery and patient care.

- Using the methodologies employed in this project it would also be useful to conduct a comparative national study of leadership and patient care across specific services (e.g. cardiology, care of the elderly). This would again be greatly enhanced if it could be linked to local and NHS policies.
- A small-scale in-depth longitudinal study of clinician/patient interactions and leadership practices, once again using mixed methods. This would provide invaluable data on both *sustainability and changes* in organisations that impact on quality of patient care.

Target-driven leadership *for its own sake* runs counter to most of the above recommendations and thus potentially subverts effective service delivery and patient care (as witnessed in the case of the Staffordshire FT for example). Thus it follows from our study that the wisdom of continuing the target-driven culture needs to be reconsidered or at least more effectively linked to the primary task of delivering good quality patient care which may indicate the need for reconsidering resource and boundary issues in a more closely informed way.

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.