Institute of Governance
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LEADERSHIP IN HEALTHCARE

A REVIEW OF THE LITERATURE FOR HEALTH CARE PROFESSIONALS, MANAGERS AND RESEARCHERS

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Professor Jean Hartley

with

Dr Jane Martin
Professor John Benington

Institute of Governance and Public Management (IGPM)
Warwick Business School
University of Warwick
Coventry CV4 7AL
Phone: (44) 24 76 574668
Fax: (44) 24 76 524410
Email: J.Hartley@warwick.ac.uk

EXECUTIVE SUMMARY

This executive summary is based on this book, commissioned by the National Institute for Health Research Service Delivery and Organization Programme. The research has been carried out by researchers at the Institute of Governance and Public Management (IGPM), at Warwick Business School, University of Warwick.

The work has **two key objectives**:

- To review the literature on leadership in healthcare and design a framework which synthesises the literature and provides a clear "road map" of the key areas of the literature and evidence.
- To draw out lessons for policy, practice and future research in the area of leadership in health care.

The research and writing was carried out in such a way as to ensure that the evidence was both extensive and contemporary. The researchers:

- Reviewed the literature on leadership and leadership development, mainly but not exclusively in healthcare. This included a focused systematic literature review of the academic and policy literature of leadership in healthcare in the last 10 years.
- Drew on wider literature about leadership and leadership development where it was felt to have direct relevance to healthcare.
- Tested the draft chapters with academics and practitioners in order to ensure that the book is clear, convincing and has practical applications.
- Ensured that the review is contemporary by contacting key UK and international researchers in the field of leadership and healthcare leadership for their latest work.

This executive summary is also available as a free-standing document.

This book will be of interest to anyone who exercises leadership in relation to healthcare. This will include those who have a formal leadership position in a healthcare organization (e.g. chief executive, clinical director, doctor,

nurse manager) or those whose leadership is through influencing opinions and actions relevant to healthcare (e.g. local government elected members and officers, patient groups).

This book examines the degree to which there is an evidence base for ideas and practices about leadership and to apply rigorous thinking to how such ideas can be applied. "Evidence-based" medicine has gained considerable ground over recent years, and there is a growing interest in evidence-based management as well. Of course, being located in social science not medical science means that the evidence base for leadership will always be more ambiguous and open to varied interpretations than medical science. However, having a clear sense of which leadership ideas and practices are rooted in theory and evidence, and which are more speculative, can be very helpful for healthcare leaders surrounded by conflicting advice, or being urged to behave in particular ways because it is fashionable. Having a clear "road map" of the terrain of leadership will help to avoid at least some of the pitfalls, fallacies and fantasies about leadership.

A FASHION FOR LEADERSHIP?

Leadership is currently quite a trendy topic. This is true across the private, public and voluntary sectors, with new books and articles being published by the day. The interest in leadership is very evident in the public sector. There has been a series of policy-papers asserting the importance of leadership in public service improvement. In the last decade, a number of dedicated leadership centres have been set up for particular public service sectors including central government, local government, schools and police amongst others.

Health is no exception to this interest, where leadership is seen as central to improving the quality of health care and the improvement of organizational processes. The NHS Plan, produced in 2000, argued for more attention to be paid to leadership and the development of leaders. More recently and very prominently, the Darzi report (*High Quality Care for All*) places considerable emphasis on healthcare leadership, especially but not

exclusively by clinicians as the NHS tackles new challenges. From the opposite end of the argument, some of the high profile media cases of lapses in professional care have, in part, been attributed to leadership problems.

Is leadership just a fashion, which is blowing through the healthcare sector and will blow out again? Is it just new fancy language to describe what has always happened in hospitals, surgeries and schools across the land? We think there are several reasons why leadership – across the organization and across healthcare networks – needs to be taken seriously:

- There are new challenges in healthcare - the kinds of illnesses are changing. For example, the major post-war curable diseases, such as measles and diphtheria are largely conquered but instead chronic and multiple diseases associated with a larger elderly population, and chronic diseases due to lifestyle choices (such as obesity and smoking) are becoming more important. How can leadership be used to anticipate rather than just react to changes in demographic and disease profiles?
- There are new health goals. Partly due to the changing nature of illness but also to address longer-term pressures on budgets, "predict and prevent" become more important goals alongside "treatment". Health not just sickness is of concern. Healthcare in the community not just in hospitals and clinics is important. Public health may be moving to the centre of health policy - and working with partner organizations becomes increasingly important. How can leadership be deployed to shape these new goals, and to ensure that there is a close link between ideas and practice on the front-line and between different partners?
- The expectations of patients, carers and communities are shifting, with more widespread knowledge about health available via the internet, less deference for professional authority, and higher expectations of personalised and flexible care. What are the implications for healthcare organizations and their staff and how can

leadership be used to ensure that these changes are responded to appropriately?

- There are new techniques and technologies in healthcare, requiring new ways of working within and across teams, and with patients. Who can lead such changes and how might they be carried out?
- The organizations of healthcare are changing – not only new structures, such as Foundation Trusts, but also, in places, new cultures and ways of working. How might such changes be led?
- New approaches to continuous improvement, which rely as much on 'people management' as on the techniques themselves, are being introduced. How can leaders support staff to make and sustain improvement efforts, in order to improve the service to the patient?
- New thinking about leadership is helping to shift thinking away from a 'one best way' model of leadership but rather thinking about a range of approaches and methods.

These are just some of the reasons why leadership is important in healthcare.

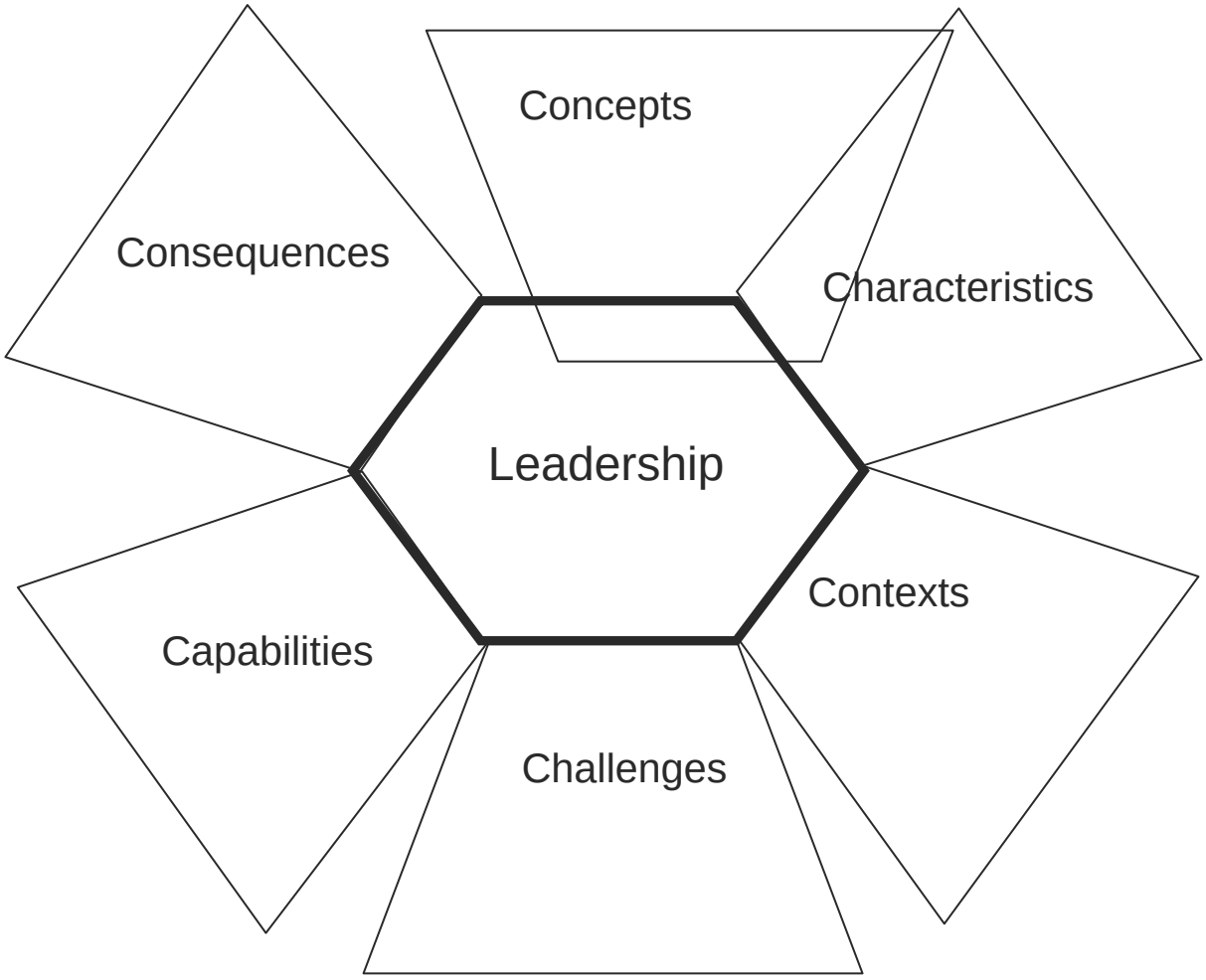
A FRAMEWORK FOR THINKING ABOUT LEADERSHIP

Much writing on leadership is very descriptive and anecdotal. For example, leadership manuals and books often begin with a set of prescriptive behaviours, competencies or qualities required in leaders, and some assertions about the impact that leadership has on team or organizational performance. A large number of books and articles on leadership consist either of a list of ideal traits or behaviours, without any theory or context. Some may provide a set of guidance principles of the 'do this, don't do that' kind. These tend therefore to be aspirational and prescriptive about the good qualities of leadership or the skills and behaviours that are shown by effective leaders. This has been described as the 'heroic' approach to leadership. In such narratives (and they are often stories), the focus is generally on the leader as an individual.

The individualistic focus of much leadership writing means that there are relatively few frameworks for taking a more holistic or system-wide view of leadership. Such frameworks are few and far between, but they are very important if leaders and potential leaders are to take an overview of the field and to have a "roadmap" for their own practices and reflections.

The lack of satisfactory integrating frameworks has resulted in the development of a Warwick "road map" for leadership. This provides the means by which to evaluate the leadership literature and to provide an overview which takes into account key elements affecting leadership processes and outcomes. This is shown in Figure 1 below. The framework is also the basis on which the book is structured.

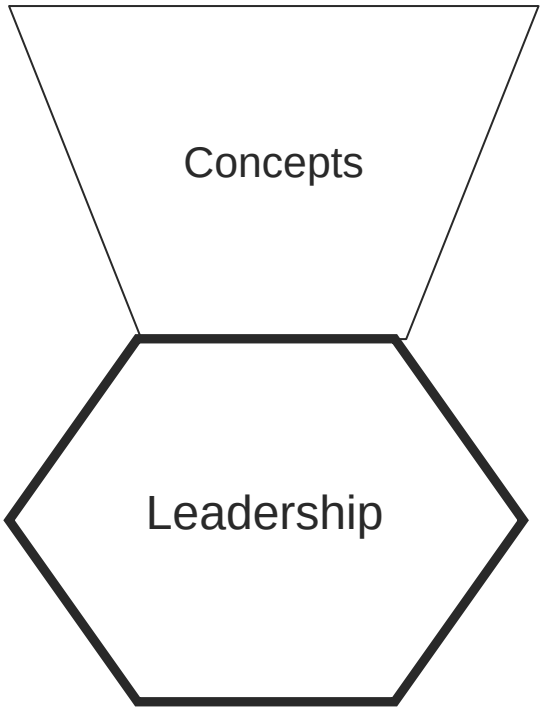
Figure 1: The Warwick road map for thinking about leadership



This roadmap therefore addresses six Cs in relation to thinking and practice about leadership:

- Concepts – what do we mean when we talk about leadership?
- Characteristics – what roles and resources are available to leaders and how do leadership roles vary?
- Contexts – what do leaders need to be aware of in the wider environment?
- Challenges – what are the key challenges, purposes or aims of leadership?
- Capabilities – what skills and abilities help a leader to be effective?
- Consequences – how can we tell whether leadership is effective?

THE CONCEPTS OF LEADERSHIP



We examine the concepts of leadership. Why use the plural (concepts) rather than the singular (concept)? There are very many definitions of leadership and in everyday speech and in academic writing there are myriad ways in which the term is used. Many writers avoid the complexity entirely and fail to indicate what they mean by leadership!

An early definition of leadership is still helpful:
"Leadership may be considered as the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement"

We use a three-fold typology of concepts to reflect the relative emphases placed on:

- the personal qualities of the leader
- the leadership positions in the organization
- the social interactions and relationships of leadership

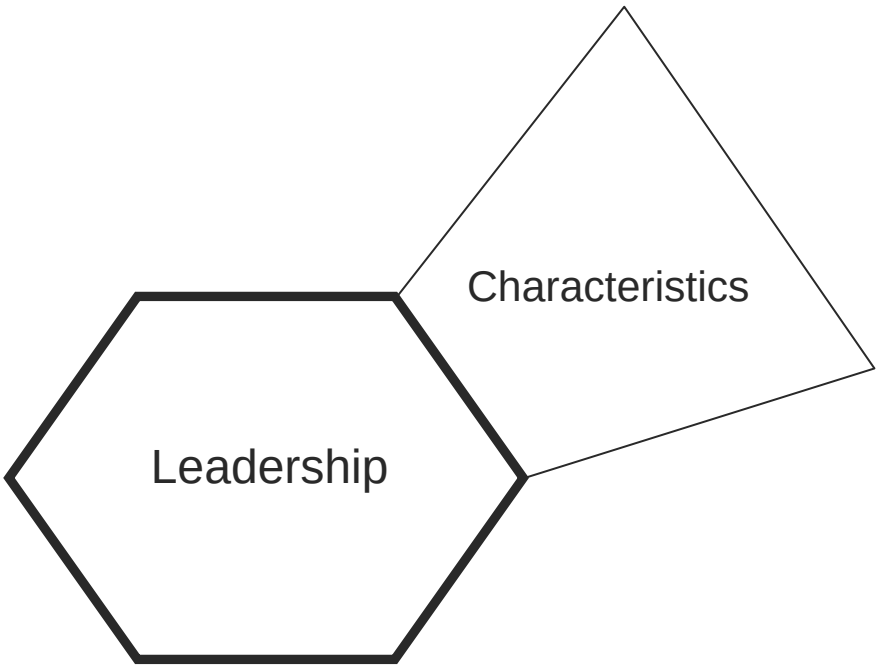
These have also been called the person, position and process approaches to leadership.

- How leadership is understood will have an impact on how and where we recognise (and accept leadership). If leadership is seen as primarily about particular individuals with special accomplishments (heroic individuals even), then there may be under-recognition or acceptance of the contributions which others in the team or unit can make.
- If leadership is understood as primarily about position in the organization then the focus on leadership will be primarily on the upper echelons of the organization and the opportunity to cultivate and practice distributed leadership may be impaired.
- If the concept of leadership is primarily about social processes of influence and mobilisation, then attention will need to be paid to how the leader understands, interacts with and engages with the group. Leadership through influence requires the cultivation of interpersonal skills and emotional intelligence, among other things.

In practice, leadership may have elements of all three of these concepts in various combinations. Confusion about leadership in discussions can be avoided by paying attention to how people understand and use the term leadership.

Researchers need to be clear and explicit about how they are using the term leadership, otherwise confusion abounds.

CHARACTERISTICS OF LEADERSHIP



If leadership is thought of as influence in relation to other people in the setting or pursuit of goals, then potentially everyone working in health care can be a leader at some time, for some purposes. On the other hand, there are differences between the context, power base, purposes and practice of leadership between, say, a hospital chief executive and a ward sister, or a medical director and a Department of Health policy advisor. So, who are the key leaders in health, and can we define some of the characteristics of varied types of leadership in order to understand more about how they influence others? This takes us into a consideration of the roles of leaders and the resources they have available to them (sources of power and influence) in both organizational and network settings in healthcare.

We examine several dimensions which help to clarify the basis of power and authority, and the resources available to different types of leadership.

- Formal and informal authority. There is a useful distinction between leadership *with* authority and leadership *without* authority.

Leadership research has made insufficient distinction between these, yet they affect the basis of leadership and the strategies of leading which are open to the person or group. Formal authority is an important form of leadership in healthcare (for example, the scope of authority implied in a job description, or the authority which is accepted and indeed expected from those in senior positions, whether clinical or managerial). Leadership without authority, or informal leadership, has a different base and therefore set of activities associated with it. These are individuals and groups who lead societies, communities, groups or particular issues (either inside or outside the organization) and influence others without formal authorisation, for example, a campaigning group or an opinion leader. A leader acting without authority may be less constrained by the roles and rules, and by the expectations of others (i.e. those who confer the authority) but there are risks.

- Direct and indirect leadership. Direct leadership is face-to-face leadership, which often occurs at the front-line. This is where others in the team or group are used to seeing the leader daily or regularly in face-to-face working. Direct leaders are likely to be able to get to know those they work with and influence them on an interpersonal basis. By contrast, indirect leadership is exercised, for example by chief executives, where the leader has an influence on others through the chain of command in the organization but where the relationship is too distant to be based on actual interaction. Indirect leaders are often interested in shaping the organizational climate, communicating a vision, and taking advantage of symbolic acts of leadership.
- Clinical and non-clinical leadership. There are different sources of expertise in these different roles, and different sources of power (located both inside and outside the organization).
- Political and organizational leadership. Political leadership differs from organizational leadership because the basis for authority is different as politicians are elected not appointed and they have a responsibility to

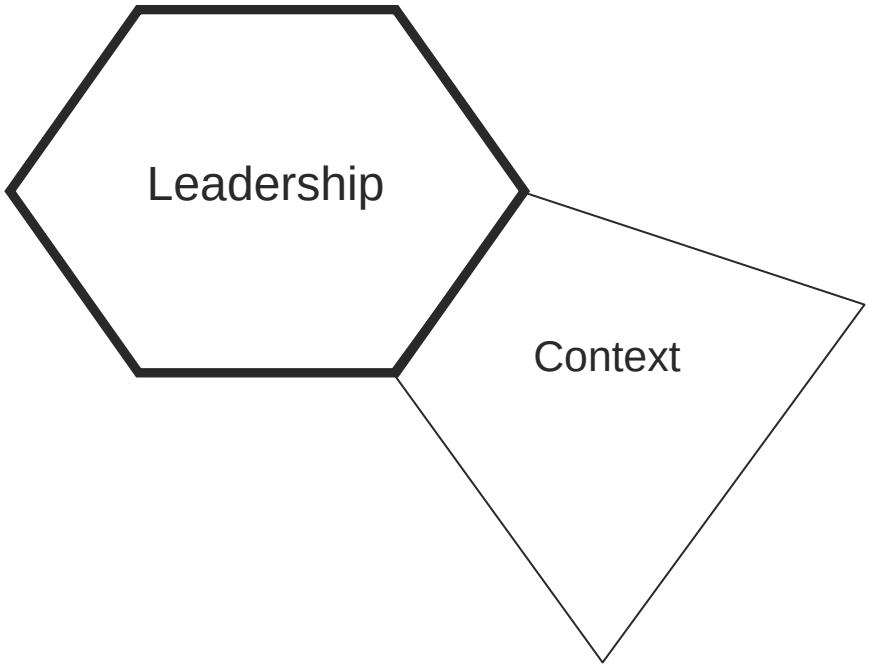
make decisions on behalf of the various stakeholders who elected them (and future generations).

- Individual and shared leadership. Some leadership roles are based on individuals and their contribution, often because they are in a role of formal authority or have to exercise leadership through the organizational hierarchy. However, it is recognised that it is increasingly difficult for a single person to accomplish the work of leadership, because of the pace and volatility of change in the external environment of organizations, (whether in the private or public sectors). Shared leadership is particularly relevant to working in partnerships inside and outside the organization and is most effectively deployed where tasks are highly interdependent, complex and require creativity. Distributed leadership is the idea of thinking about leadership as a quality of the whole organization, network or system. It suggests that leadership can be practiced at different levels of an organization and is not just the preserve of senior executives.

Too much mainstream writing on leadership has assumed a uniformity of leadership – as though it is simply a universal process of influencing others and that there is 'one best approach' to leadership. But this consideration of characteristics shows that the role and the resources (e.g. authority, information, reputation, resources, expertise) can vary enormously. This explains why there are different types of leaders in and around healthcare organizations. It also explains why leadership cannot be considered solely from an individualistic perspective.

There is scope for more research which examines differences (and similarities) in the leadership behaviours and processes according to different leadership characteristics. For example, there is little detailed empirical research about clinical leaders across a range of professions.

THE CONTEXTS OF LEADERSHIP



An important strand of thinking in leadership studies is the relationship between what leaders do and the contexts in which they do it. It is generally agreed that leadership is related to, or contingent on, context and that a key prerequisite of effective leadership is the need to understand the context in which it is being exercised. Theorists have looked at this from a number of perspectives, exploring both the influence of contextual factors on leadership and the influence of leadership in shaping context. However, there is much less work than might be expected on this crucial set of interactions between leadership and context which explores context analytically rather than simply stating that it is important.

Early research was influential in understanding how leadership varied by context, and the extent to which leadership was effectiveness by matching leadership style to context. Different leadership styles are more effective depending upon the level of control the leader has in any given situation, suggesting that the leader should modify their style according to how much control they had over the situation they are in.

This suggests that one key leadership skill is the ability to read different situations and respond appropriately. Alignment might then be achieved in two ways. One is by selecting particular leaders for particular contexts. The second way is to encourage a leader to learn to be versatile, i.e. to adapt their style to the particular context.

In spite of legislative and organizational constraints for public service leaders, there is an interpretive space within which leadership capabilities come into play, interacting with context. Reading context includes being able to take an overview of the external and internal conditions and opportunities, and also to be able to move between 'the balcony and the battlefield', in other words to be able to link the small detail to the big picture. Skill lies in being able to sense the 'soft' points in the political, organizational or partnership culture where the leader's priorities can be taken forward without provoking stubborn opposition. In addition, how the leader defines a situation and frames it for other people is a key element of leadership.

We suggest that leadership in healthcare can be thought of as being situated within three 'layers of context': the national political and public policy context; the regional/local context at the level of the health economy, and the organizational context. The boundaries between the layers are blurred and aspects of context may be evident at more than one layer.

Layers of context are likely to be dynamic and changing. Leadership within healthcare organizations does not operate within a static context but rather needs to take account of the trajectory of public policy, the implications of political change for strategy and the current and recent state of the organization including its degree of improvement (and capacity for improvement).

Within the UK NHS, whole systems thinking is helpful to understanding how these layers of context are part of an open system of complex networks rather than linear cause and effect relationships.

National healthcare systems can be said to be ‘context heavy’. They are necessarily affected by political, economic and social factors from the wider society, and in the introduction to this book we outlined some of the pressures of health change, public expectations and so on. The national healthcare policies and their local impacts have included an increased focus on the role of leadership to achieve sustainable and substantial change, and hence leadership development is an important issue across all levels and professions. This is a significant contextual framework for leadership in healthcare.

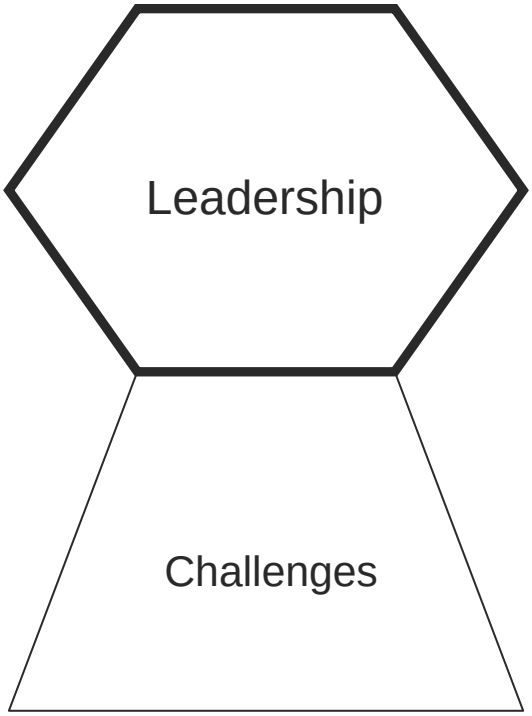
A further layer of context is that of the regional or local health-care system. ‘Reading the context’ at this layer has two key elements. One is about reading the context of complex inter-relationships at the regional/local level and the second is working out how to lead effectively in this context, which currently uses partnership working as a major means of leading and managing in that context. Leadership frameworks, by and large, have not yet caught up with the major changes which are taking place in the way that organizations operate – the increases in inter-relationships both through networking, joint ventures and strategic alliances and the greater impacts that a range of stakeholders such as lobby and campaigning groups may have on organizations in the private, public and voluntary sectors.

The context at this intermediate level is about the inter-relationships between a complex network of commissioners, providers, regulators and opinion-formers with various organizational competencies and responsibilities. The network includes those organizations whose activities have an impact on public health and on healthcare treatment, such as the local authority, the police and the voluntary sector. There is a need for leadership to focus on system design and also on partnership and organizational development. This becomes particularly relevant in the newer context of ‘worldclass commissioning’.

The organizational context, or internal context refers to aspects of size, geographical location, structure, culture, staffing, skills and resources. The

internal environment of the organization will represent strengths and weaknesses and as such is an important part of the context for the leader to 'read' and understand. Leadership rarely starts from scratch but has to work with the existing internal context. Some studies stress the importance of assessing the alignment between organizational culture and the wider environment, including acknowledgement of possible 'cultural lag' or 'strategic drift' in achieving alignment. An integrated leadership style (both transactional and transformational) is more likely to achieve culture change. Being aware of the informal as well as formal aspects of the organization is important.

THE CHALLENGES OF LEADERSHIP



Leadership theory from the 1980s onwards has emphasised the role of leadership in providing 'vision' and a sense of clear purpose and direction for the organization. Yet vision is not a simple read-off from the context. Some have argued for a more constitutive approach which is about the active framing of what is the problem as well as what is the solution (or range of ways of addressing the problem). How are purposes formulated, articulated and debated? The complex context of healthcare makes this a particularly

fertile site for the exploration of purposes and the contestation of purposes by different stakeholders.

Complex change in an uncertain world can only be partially predicted and planned for. Therefore, sense-making becomes important in organizational change under conditions of uncertainty or ambiguity. Sense-making captures the idea that people (individuals or groups) make sense of confusing or ambiguous events by constructing plausible (rather than necessarily accurate) interpretations of events through action and through reinterpretation of past events. The role of the leader, in a sense-making framework, may be less to be fully clear about the future and rational plans for shaping it (i.e. providing a 'clear vision'), and more about being able to provide a plausible narrative that helps people understand what may be happening and mobilises their support and activity towards addressing the problem.

A number of writers have distinguished different types of problem or challenge and argued that they call for different types of leadership. The distinction between 'tame' and 'wicked' problems has been a valuable way to think about and practice leadership. Tame problems are ones which have been encountered before, for which known solutions already exist and which can be addressed by a particular unit, profession or service. Tame problems may be complicated but they are resolvable through existing practices. Wicked, or cross-cutting problems have no definitive formulation (different people may formulate the problem differently), are incomplete and have changing requirements. Another similar approach makes the distinction between 'technical' and 'adaptive' problems. This distinction in the type of problem encountered has major implications for leadership strategies, styles, processes and behaviours. Tame/technical problems, where the parameters are known, can be dealt with through management or through technical leadership. This is the leadership required to bring together resources, people and schedules to deal with the challenge, often in a project-based way. Wicked/adaptive problems require adaptive leadership where the leader must mobilise a range of people to focus on the problem, recognise their

responsibility in addressing it, and gain their contributions to solving it in new and creative ways.

Turning from how challenges (purposes) are defined, leadership also has to address how to tackle the challenges. In addressing any kind of leadership problem, public leaders and managers need to think carefully about three elements which are needed for a successful strategy. The three elements of 'the strategic triangle' are: public value (is there a value proposition in terms of the public sphere, i.e. is the proposed goal or change defensible in terms of its contribution to public services); commitment from the 'authorising environment' (are the stakeholders who can provide or withhold legitimacy or approval supportive of the value proposition); and operational resources (is there sufficient money, people, skills and other resources for the change).

For leaders in the NHS at every level perhaps the biggest challenge is the pace of organization and system change so the book examines five challenges, or purposes which are highly relevant in the healthcare field: organisational mergers and acquisitions;

- networked or partnership organizational arrangements;
- leading organizations out of failure
- organizational change, innovation and improvement
- nurturing future leaders

Styles or types of leadership may vary with the purposes being pursued at any phase of the organizational changes. For example, transaction and transformational leadership styles are both relevant at different phases of merger/acquisition. Complex organizational change, such as mergers, may also be made more effective by relying on a 'leadership constellation' not just an individual leader.

The leadership challenges of working in networks and partnerships are complex because leadership is generally fragile in conditions of diffuse power.

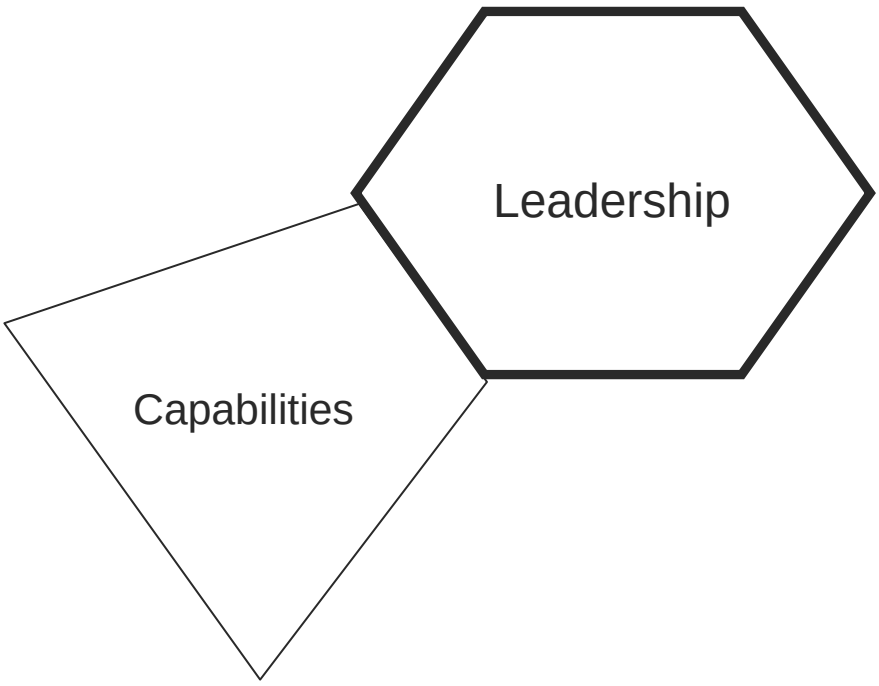
The leadership challenge is to prevent internal rivalry, dislocation from the focal organization and lack of adaptation to environmental needs.

Managing turnaround requires the building of leadership capacity and the use of legitimising actions (to reassure external stakeholders) as well as internal activity to overcome inertia and generate confidence to improve.

Organizational change and improvement is the task of both formal and informal leaders in the workplace. Some may be constrained by role expectations and organizational culture, suggesting that such changes need to be whole system approaches. Innovation and improvement are different in scope and scale and may require different types of leadership. Innovation requires empowering others to be creative and creating an organizational climate with psychological safety.

A further job for is nurturing future leadership talent so that leaders actively develop future generations of leaders.

THE CAPABILITIES OF LEADERSHIP



This book is based on an analytical framework which argues that the context and the challenges shape the kinds of leaders who will emerge in particular situations, or who will put themselves forward, intentionally or not, as sources of influence. So, this approach is a contingent one, which suggests that the kinds of skills and abilities which an effective leader exhibits will depend on the situation they are in, and the kinds of goals they are trying to formulate or accomplish.

Early research focused on the traits, or personality of leaders but the research was inconclusive. Disappointment with trait theory led to a greater interest in the behaviours exhibited by leaders from the mid-twentieth century onwards. This meant that there was a focus on what leaders do rather than on who they are (in the sense of personality or background). This is also called the style approach, in that it examines clusters of behaviour commonly used by leaders. Here, the focus is still on the individual leader, but examines what can be explicitly seen or sensed through behaviour. It also assumes that behaviours can be acquired so there is a shift from a dominant interest in selection, to a focus on leadership development.

An important approach to understanding the behaviours of leadership has come from the competency frameworks, widely used both to understand and to improve leadership qualities. A competency can be defined as the "*underlying characteristic of the person that leads to or causes effective or superior performance*". More concretely, this has been described as skills, knowledge, experience, attributes, mindsets and behaviours. Competencies, or capabilities, are conceptualised as related to job (or role) performance. A competency approach recognises (or should recognise) the interaction between the context and the person. Competency frameworks have become a widely-used approach to thinking about the skills of leadership. For example, the NHS Leadership Qualities Framework has been widely used in healthcare in the UK.

Some have argued that a competency approach to leadership is restrictive because it creates abstract qualities about leadership. In this restricted use,

the focus can become blinkered to concentrate solely on the person's individual behaviours, at the expense of understanding the context or the job demands and their interactions with capability.

Most competency frameworks cover a range of personal, social and cognitive, or conceptual skills. For example, personal skills may include self-awareness, confidence, integrity, resilience in the face of adversity. Social skills might include the ability to empathise with others, to communicate clearly and persuasively, maintaining cooperative relationships. Conceptual skills might include analytical ability, creativity, having foresight, making sense of complexity.

Some elements of leadership capability have received particular attention recently. It is not within the scope of this book to cover them all, but we look at three capabilities: emotional intelligence, political awareness and metacompetencies.

Emotional intelligence has captured the interest of policy-makers and practitioners, because it emphasises the need to understand one's own and others' emotional states and capacities. It counterbalances more rational approaches to leadership which have focused on analytical skills. Both may be important.

Leadership with political awareness is emerging as an important set of skills, as leaders at a variety of levels have to understand and work with diverse stakeholders inside and outside the organization, both locally and nationally.

There is increasing interest in the competencies which enable leaders to acquire new competencies. These meta-competencies include accurate self-assessment including modifying one's self-perception as one's attributes change; and also being receptive to and comfortable with change and challenge.

The increasing interest in distributed leadership means that capabilities shared across a team or a board, or across the leadership of a group of organizations involved in partnership working is becoming more important. There is still relatively little work on the capabilities of whole teams or governance groups, much less research within the health sector.

Bringing about major organizational change in complex healthcare systems is more likely to happen where there is a "leadership constellation" in which different individual leaders play different roles or contribute different aspects of leadership at different phases of change, and where leadership roles are constructed and reconstructed as the change progresses. A leadership constellation may be particularly important in organizations with multiple professions, priorities and views (such as hospitals) where a coalition to define, build support for and engage in leadership is critical.

Some theories are focused on the relationship between leaders and those they try to influence. One has particular prominence in healthcare leadership research, is influential but is sometimes misunderstood.

Transformational leadership theory has been developed, alongside its apparently contrasting cousin, transactional leadership. Transformational leadership is based on the leader engaging with their 'followers'. The leader aims to engage followers in going beyond their self-interest because the leader seeks to win their trust, admiration and loyalty and so they are emotionally as well as rationally inclined to do more than they originally expected to do. Transactional leadership is based on an exchange process between the leader and followers. The transaction is based on what the leader possesses or controls and what the 'follower' wants in return for providing their services.

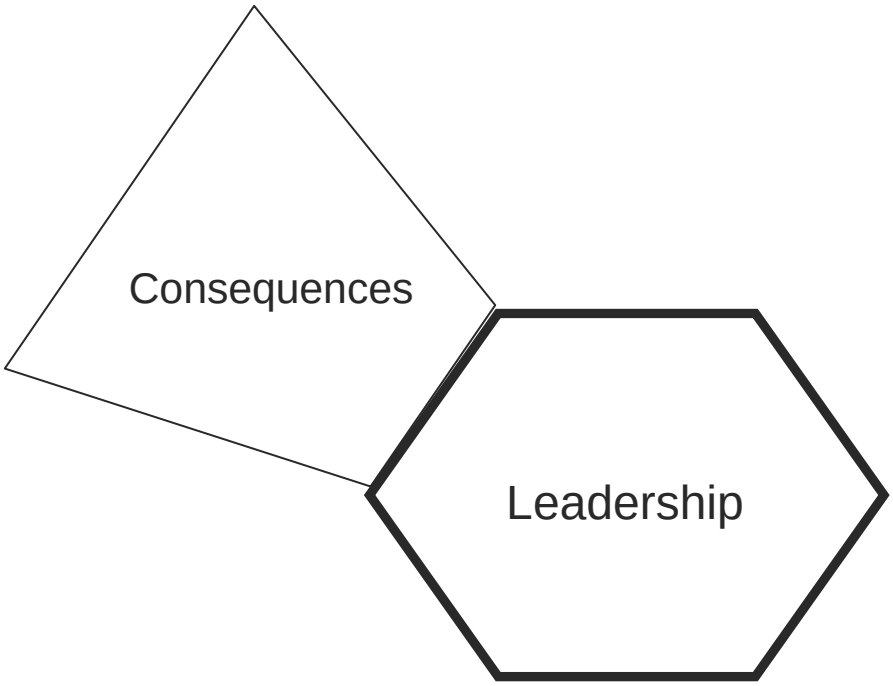
Transformational leadership has been very fashionable, and the view is sometimes heard that transformational leadership is 'better' than transactional leadership because it rises above a kind of pragmatic, cost-benefit analysis and exchange (transactional leadership) to engage followers emotionally in

higher aspirations and goals (transformational leadership). However, the research evidence shows that effective leaders may use both types of behaviour styles, and that different styles may be relevant in different contexts.

Transformational leadership emphasises the need to inspire others with a strategic purpose and to engage with hearts as well as minds. It is a relational view of leadership i.e. it is based on how leaders interact with others, rather than on abstract qualities in isolation. The approach, by focusing on style, implies that many of the behaviours can be learnt, fostered and developed. The focus on empowering others through intellectual stimulation, individualised consideration and so on means that it can help organizations to think about the 'leadership pipeline' as well as existing leaders i.e. helping to foster the next generation of leaders. However, there is increasing caution about the charismatic element of transformational leadership (arousing strong follower emotions) in public service (and other) settings. As a result, there is interest in 'post-transformational' leadership which is focused on creating a climate of organizational learning.

There is sometimes speculation that women make better (or worse) leaders than men. The research evidence on individual capabilities is very weak indeed, suggesting considerable variation in the leadership capabilities of men and women. So it is not helpful to assume that women (or men) have particular leadership styles. This is valuable for thinking about diversity more generally.

THE CONSEQUENCES OF LEADERSHIP



The impact of leadership on public services is often asserted, but the evidence is more fragile or incomplete. There is more writing about leadership in general descriptive terms than there is detailed research evidence. Also, some writing is vague about what is the outcome that effective or influential leadership is expected to produce - what are the indicators and/or measures of performance as a result of, or associated with, leadership.

There can be attributional problems as to whether and how commentators see the impact of leadership. The assumption is sometimes made that leadership results in improved outcomes implying a causal link from leadership to outcomes. However, it is also possible to have situations where group members believe that leadership is effective because there are positive outcomes. There are also situations where the attribution is reversed but negative – where 'followers' attribute negative qualities to the leader where a situation does not meet expectations. There may also be situations where the leadership is so subtle or so participative that commentators are not aware of the full extent of the leader's role in achieving outcomes.

These reflections on attributions capture the issue that how people construct meanings from leadership acts, roles, contexts and experiences affects whether and how leadership is seen to be effective. Leadership and leadership effectiveness is socially constructed, not just read off from actions and behaviours. The quality of the relationship between the leader and the people being influenced, and the organizational, cultural and policy context may all affect the extent to which leadership is viewed as effective. This also means that the evaluation of leadership is not straightforward.

The book utilises two frameworks for thinking systematically about potential impacts. The first focuses on three key themes of organizational performance. These are the impact of leadership on: efficiency and process reliability; human resources and relations; and innovation and adaptation. Each of these themes can consist of a number of elements.

Looking beyond an organizational focus, a public value perspective recognises the contributions which leadership can make beyond the immediate organization or partnership to consider the benefits to the wider society. One feature of organizations providing goods and services for the benefit of the public (whether in the public, private or voluntary sectors) is that they are embedded in society, producing not only benefits (and obligations) for individuals but also providing goods and services which may benefit (or detract from) the wider community and society, for example, reducing the risk of diseases in the community, preventing climate change, building public trust and confidence in the healthcare system, establishing collective efficiency and collective rules and purposes. In terms of healthcare, it is possible to think about not only activities and services to treat illness and disease, but also the contributions which healthcare can make to illness prevention, and to a societal culture in which people take responsibility for many aspects of their health through their lifestyle choices. A public value perspective argues that healthcare can incorporate attention to promoting wellbeing (physical and mental) not just treating illness. A public value perspective also becomes increasingly important as the UK health service shifts more into 'predict and prevent' rather than just 'treat'.

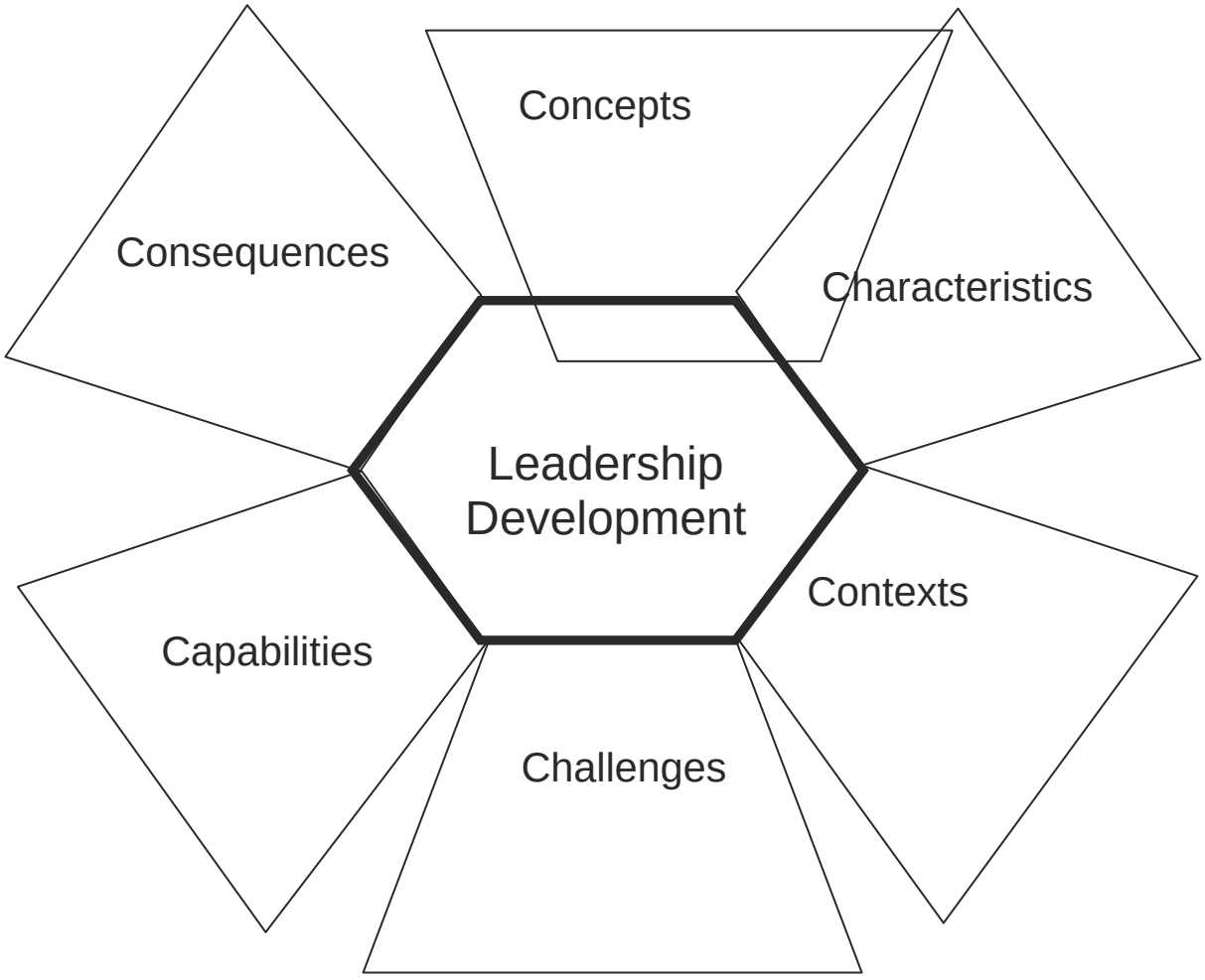
Public value can be conceptualised using the value chain. The attraction of the value chain is that it enables the added value of a public service such as healthcare to be assessed at each stage. A key question is whether and how leadership can contribute to the public value chain. Using the public value chain directs attention to the contribution which can be made at various stages: to inputs, activities, partnerships, outputs, user satisfaction, and outcomes (both for patients and for the wider society).

There is a fair degree of evidence that leadership can have an impact on staff attitudes. Both transformational and transactional leadership can contribute to job satisfaction but transformational leadership seems to have a greater impact on a sense of empowerment. Direct leadership is particularly significant for staff attitudes.

The impact of leadership is also affected by organizational context, including type of task, type of team, organizational culture and roles.

Leadership has a substantial role to play in creating organizational climates which support patient safety and a commitment to quality improvement. More effective senior management is associated with fewer patient complaints. While there has been a strong fashion for transformational leadership, research on leadership style and trust ratings suggests that transactional leadership can be important for creating and maintaining effective performance management systems.

FROM LEADERSHIP TO LEADERSHIP DEVELOPMENT



Leadership development concerns the activities which are used to enhance the quality of leadership and leadership potential in individuals and in groups and across the whole organization.

It is possible to now use the analytical framework, the Warwick “road-map” to reflect on how the understanding of leadership affects thinking and practice in relation to leadership development. We continue to draw on evidence from healthcare and other sources, but use the framework placing leadership development in the centre of the framework. Leadership development is itself a large area, but here we focus on particular aspects about the selection of staff for leadership development, the design of leadership development, and the evaluation of leadership development.

Research shows that leadership development is often embarked on organizations with insufficient attention to the implicit or explicit model of leadership which is being used, either by leadership development commissioners or providers. There is sometimes an implicit belief that leadership development is 'a good thing' without clear planning to ensure that it fits with the strategic direction and priorities of the organization, that it is supporting appropriate skills and values, that it is efficient in resource terms, and contributes not only to individual development but also to organizational change and improvement.

There is sometimes also a view that there is a 'right' or 'best' (universal) approach to leadership development, but a number of writers have dismissed this, arguing instead for the alignment of leadership development with organizational purpose, practices and people.

Until recently, the focus of leadership development has been on formal training and education programmes. While these are still important, there has been greater recognition a range of experiences, including informal and intended activities and experiences can be very formative in developing the skills of leadership.

One useful model outlines two dimensions of leadership development. The first is the extent to which leadership is conceptualised as about individuals or collectives (e.g. distributed leadership, shared leadership). The second dimension is the extent to which leadership is prescriptive or emergent. By prescriptive is meant that it is possible to define the inputs (e.g. skills) or the outputs (e.g. standards) required for leadership in particular organizational settings. Emergent approaches to leadership development see it as developing through dynamic processes, in interactions between leaders, followers, context etc and therefore that leadership has processes and outcomes which cannot be predicted in advance. This leads to four quadrants of leadership development and leadership development evaluation.

The literature shows that the approach to development is influenced by the model (explicit or implicit) of leadership being used. Unless there is a clear and agreed approach to the concept of leadership and an agreed framework, then leadership development practices may be inappropriate for the kind of leaders which the organization is aiming for (e.g. developing transactional leaders when the organization needs transformational leaders) or old and out-dated practices may be relabelled as "leadership" to suit the current organizational rhetoric.

If the concept of leadership is a 'heroic' one i.e. the notion that leadership is about exceptional individuals, then there is a danger that leadership development will focus on personal development to the exclusion of, for example context. It is also likely to focus more on selecting the 'right' people for development opportunities, rather than widening the opportunities for development across a group or organization. If leadership is thought of a set of influence processes between individuals, groups and organizations, then a different set of leadership development activities may be devised. But a focus on 'process' alone may create a rather lop-sided approach to leadership development, which under-emphasises context, roles or resources.

In relation to characteristics, leadership development activities need to be geared to the roles and resources of those in leadership positions. For example, where a leader is a 'near' leader, with daily interaction with those they influence, then the focus may be particularly on interpersonal and social skills of influence. Where the leader is 'distant' then development may need to focus as well on how to influence people indirectly through strategy, communicating the vision, and thinking about how to have an impact on the organizational culture and systems. Different skills need to be developed as clinicians move from clinical practice to clinical leadership.

In addition, there is a shift in emphasis taking place from leader development to leadership development, recognising the importance of teams, groups and leadership constellations. The increasing recognition of the importance of distributed leadership suggests that leadership development may be in part

most appropriately effected through organization-wide initiatives, not just programmes for individuals.

The growing recognition of the importance of context means that leadership development which helps leaders to understand and interpret existing context and potential future scenarios is particularly important and is stressed in certain types of leadership development.

context is not just the institutional field but also the health economy, which includes a growing need to work with other organizational partners and networks, so there is a need in the NHS for leadership development across sectors and services, where sharing and comparing across organizations is seen as a key element of the programme. If the view of healthcare is from a systems perspective, then at least some of the leadership development needs to be able to help leaders and potential leaders to understand and work with a whole system.

The internal context, of the organizational structure and culture, size and history, are also important. The organizational context shapes how formal leadership development programmes are used, and also how informal and emergent experiences are drawn on. The organizational context may also influence whether the main focus is best located on the individual, the team or group, sets of roles (e.g. medical directors, aspiring chief executives; fast track programmes) or concerned with the whole organization (e.g. organization development). The organizational culture and procedures may also have an impact on who is seen as "leadership material" and who gets access to formal leadership development activities. The organizational context may also affect how far there is a transfer of training back in to the organization after the leadership development programme.

Turning to think about the challenges (purposes) of leadership, leadership development programmes can focus on and help leaders to tackle these the defining and construction of problems and purposes. A focus on problem-identification not just problem-solving is increasingly being thought of as a key

skill for leaders and managers. Interpreting the type of challenge and the ways of leading responses is an important issue for leadership development. Distinguishing between technical and adaptive problems (tame and wicked problems) is an important skill to develop.

Knowing how to influence others to change accepted patterns and practices in the workplace, how to encourage innovation and the considered management of risk are important leadership skills to be developed. These may be a mix of 'adaptive' challenges and of 'technical' challenges.

Some challenges lie outside as well as inside the organization. There is more work to be done in understanding the leadership of partnerships, of working with local communities, and with working with elected politicians. There are questions as to how far are the current leadership development programmes in any given setting are addressing these challenges. And is the NHS making sufficient use of the potential for learning arising from job and organizational leadership challenges?

The area of capabilities is a traditional focus of leadership development. It is is based on the assumption that capabilities (competencies, qualities, skills, mindsets) can be learned; that they are primarily acquired rather than inherited. There is now considerable evidence from a variety of sources that many leadership qualities can be learned, even for many of those skills where some people have a natural aptitude more than others.

Capability models lie at the heart of many leadership development programmes, with a great emphasis on first defining a skill set (or more widely defined as a mind-set) and then designing activities to foster and enhance those skills. However, this book has suggested that there may be dangers if leadership is not seen in a wider perspective, which includes consideration of context and the challenges of leadership. If there is anything we know about leadership, it is that it is dependent on context and challenges and the idea of a universalistic response, based on universal qualities, is not upheld by the evidence.

If the question about consequences for leadership theory is whether there is evidence that leadership has an impact on organizational performance, then the parallel question for leadership development is – how do we assess whether leadership development makes a difference to organizational change and improvement?

Unfortunately, evaluation is still quite rudimentary for a number of leadership development approaches. Problems range from an inadequate theory of leadership and leadership development such that evaluation is not possible, to inadequate data collection (or the wrong type of data collection), to making inappropriate interpretations from the evidence collected.

In order for evaluation to occur with any degree of robustness, there is a need for a reasonably clear specification of what forms the basis of the leadership development, what is the model of leadership being used, and how is the development hypothesised to impact on leadership performance and organizational performance.

As each method is used, consideration might be given to whether the impacts of leadership development are expected to be planned or emergent, and building human capital or social capital. The quadrants imply different approaches to leadership development and therefore there are likely to be different approaches to evaluation.

Where the focus in leadership development is on prescription, then evaluation is able to use a 'scientific approach', with the clear specification of goals, performance standards, competencies etc. Where the focus is on emergent properties, then evaluation will need to take a more qualitative and more formative approach, as the outcomes cannot be pre-specified.

Evaluation of leadership development has both subjective and an objective elements. The objective elements may come from organizational performance measures (though these are themselves influenced by human

Disclaimer

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Addendum

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